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FOR STATE
HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MONTGOMERY STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02389											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brinklow c. LENGTH OF STAY IN 1b MARYLAND d. XXXXXX (if not in hospital, give street address) Brooke Road						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brinklow d. STREET ADDRESS Brooke Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Corrinne Isabel Addison						4. DATE OF DEATH Month 2 - Day 6 Year 1966					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 3, 1912		9. AGE (In years birthday) 53 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Brinklow, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Powell						14. MOTHER'S MAIDEN NAME Redmond, Edna (Eddie) Jerushia					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Detective Cpl. James H. Glazier					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Charring burns, 100% of body, incurred in 9160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) house trailer fire. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased incinerated in house trailer fire.							
20c. TIME OF INJURY Month, Day, Year 3:00 Hour XX p.m. 2/6/66 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House trailer		20f. (City or town) Brinklow Montg. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Febr. 7, 1966.			
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL				22b. DATE THEREOF 2/11/66		22c. NAME OF CHURCH OR CREMATORY Ash Memorial		22d. LOCATION (City, town, or country) Sandy Spring, Md.		(State)	
23. FUNERAL DIRECTOR Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR FEB 14 1966		24b. REGISTRAR'S SIGNATURE Charles Judge			

02383

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Handwritten notes at the bottom of the page, including the name "Robert R. Keating" and other illegible text.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02433

CERTIFICATE OF DEATH

02390

Item #23b Film #G373 2723/66 pc

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY in 1b 41 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 1900 Columbia Pike Apt. 416	
3. NAME OF DECEASED (Type or print) First Irma Middle Louise Last ALBRECHT		4. DATE OF DEATH Month February Day 14 Year 19 66	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2 1909
9. AGE (In years last birthday) yrs. 56		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME G. H. Beck		14. MOTHER'S MAIDEN NAME Louise Duesing	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 537-42-4534	
17. INFORMANT Capt. Herbert C. Albrecht		Apt. Address 416, Arlington, Va. 1900 Columbia Pike	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the colon with metastases 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from Jan. 3 , 19 66 , to Feb. 14 , 19 66 , that (I) (we) last saw the deceased alive on Feb. 14 , 19 66 , and that death occurred at 155P M, from causes and on the date stated above.			
22a. SIGNATURE P. B. Blanchard, M.D.		22b. DATE SIGNED Feb. 15, 1966	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 18, 1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Ives Funeral Home ADDRESS 2847 Wilson Blvd. Arlington, Virginia		25a. REC'D BY REGISTRAR FEB 17 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02434 CERTIFICATE OF DEATH 02391

1. PLACE OF DEATH a. COUNTY <u>Montgomery City</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gordon</u> Middle <u>H.</u> Last <u>Allen</u>		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <u>July 31, 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Small Business Adminstr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Government</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>
13. FATHER'S NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>056-03-4170</u>	17. INFORMANT Address <u>Hospital Records</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> 148X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>carcinoma of the Pharynx, extensive</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>65</u> , to <u>Feb 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>February 18</u> , 19 <u>66</u> , and that death occurred at <u>12:25</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>GE Flores.</u>		22b. DATE SIGNED <u>2/18/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dino E Flores</u>		22d. ADDRESS <u>50 W. Edmonston Dr. Rockville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2/21/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>	23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>	
ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Wilmington

Wilmington

Rockville

Potomac Valley Transit House

Gordon

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Allen

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Belmont (Glenview)

Belmont (Glenview) of the (Glenview) Station

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Feb 18

DE Floor

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Bobbin

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X

20 W Edmonds Dr Rockville, Md

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02435

02392

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>2 months 25 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> d. STREET ADDRESS <i>10 Sherman Avenue</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mary Eugenia Ambrosi</i>			4. DATE OF DEATH Month Day Year <i>February 4 19 66</i>		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>7-4-96</i>		9. AGE (in years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired school teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland W. VA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>United States</i>			13. FATHER'S NAME <i>William Moore Lowman</i>		
14. MOTHER'S MAIDEN NAME <i>Clara ?</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Hospital Record.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Silent. Pulb. Embolism</i> <i>352x</i> DUE TO (b) <i>Thrombosis, femoral vein rt.</i> DUE TO (c) <i>RT Hemiplegia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Ch. Reg. Hypertension coronary thrombosis with Stent Block.</i>					
19. INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>11/27/65</i>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (this hospital) attended the deceased from <i>2/3</i> , 19 <i>66</i> , to <i>2/4</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>2/3</i> , 19 <i>66</i> , and that death occurred at <i>6:30</i> M, from the causes and on the date stated above.					
22a. SIGNATURE <i>Howard T. Morse</i>			22b. DATE SIGNED <i>2/4/66</i>		
22c. PHYSICIAN'S NAME (Type) <i>Howard T. Morse</i>			22d. ADDRESS <i>1030 Carroll Ave Takoma Park, Md</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>TEMP BURIAL</i>		23b. DATE THEREOF <i>Feb. 9, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Mausoleum</i>	
23d. LOCATION (City, town or county) <i>Calmar Manor P.A. Co. Md</i>		23e. (State) <i>Md</i>		24. FUNERAL DIRECTOR <i>Arthur Walters</i>	
24. ADDRESS <i>254 Carroll St. W. Washington, D.C. 20012</i>		25a. REC'D BY REGISTRAR <i>FEB 9 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02436

CERTIFICATE OF DEATH

02393

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>North Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b. <u>1 day 5 hrs.</u>		d. STREET ADDRESS <u>75 Adams Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edna Martha Anders</u>		4. DATE OF DEATH Month Day Year <u>Feb. 13 1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/29/92</u> 73 yrs.
9. AGE (In years last birthday) <u>73</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Fairfax Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Mary W. Bladen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT Address <u>Same</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic glomerulonephritis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary arteriosclerosis with thrombosis, right coronary artery</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-12</u> , 19 <u>66</u> , to <u>2-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-13</u> , 19 <u>66</u> , and that death occurred at <u>8:45</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>W.G. Hall</u> M.D.		22b. DATE SIGNED <u>2-13-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.G. Hall, M.D.</u>		22d. ADDRESS <u>615 W. Montgomery Ave., Rockville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/16/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 17 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02437

CERTIFICATE OF DEATH

02394

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)			c. LENGTH OF STAY IN 1b 30 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 5330 Belt Road, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Ada Middle Lenore Last Angel				4. DATE OF DEATH Month February Day 17 Year 19 66				
5. SEX Female		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1876		
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 10 Days 9 Hours Min. 		IF UNDER 24 HRS. Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Carlinville, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lemuel Sells				14. MOTHER'S MAIDEN NAME Mary Ann Moore				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 556-14-2427		17. INFORMANT Daug. Mrs. Dorothy A. Drexler, Ave. N.W. Washington D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Jan. 18 , 19 66 , to Feb. 17 , 19 66 , that (1) (we) last saw the deceased alive on Feb. 17 , 19 66 , and that death occurred at 1253 M. from causes and on the date stated above.								
22a. SIGNATURE John B. Emery, Jr.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb. 17, 1966		
22c. PHYSICIAN'S NAME (Type) John B. Emery, Jr., M. D.				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-18-66		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland Md.		
24. FUNERAL DIRECTOR R. A. Pumphrey, 7557 Wisconsin Ave., Bethesda				25a. REC'D BY REGISTRAR Feb 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02438

CERTIFICATE OF DEATH

02395

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> c. LENGTH OF STAY IN lb years <u>years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7905 Holstein Ave.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park Md. 15-</u> d. STREET ADDRESS <u>7905 Holstein Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ADRIAN</u> First Middle Last 4. DATE OF DEATH <u>Feb. 1- 1966</u> Month Day Year				5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 22-1882</u> 9. AGE (in years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg. Nurse (Retired)</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>ILLINOIS</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Harry Garrett Arkebauser</u> 14. MOTHER'S MAIDEN NAME <u>Martha Ann E. Dayton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>578-44-2064</u> 17. INFORMANT <u>MRS ESTHER ARKEBAUSER</u> Address <u>7905 Holstein Ave. Jakoma</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 1810 DUE TO (b) <u>Advanced Cancer bladder</u> DUE TO (c) <u>Operated 2 1/2 yrs ago (inoperable)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs ±</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>To be performed at A.W.U. Hosp.?</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>by phone from Beldon Road M.D.</u> to <u>Med. Exam. 19 Nov</u> , that (I) (we) last saw the deceased alive on <u>Nov 19</u> , and that death occurred at <u>Nov 19</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Read N. Calvert</u> 22c. PHYSICIAN'S NAME (Type) <u>READ N. CALVERT</u>				22b. DATE SIGNED <u>2-1-66</u> 22d. ADDRESS <u>909 Pershing Drive, Silver Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>RESEARCH</u> 23b. DATE THEREOF <u>2/2/1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASHINGTON UNIV. MED SCHOOL</u> 23d. LOCATION (City, town or county) (State) <u>1335 H. ST. N.W. WASH. DC.</u>				24. FUNERAL DIRECTOR <u>Jakoma Funeral Home Inc. 254 Carroll St. N.W. Wash, D.C.</u> 25a. REC'D BY REGISTRAR <u>DATE B 7 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J...</u>			

MEDICAL CERTIFICATION

05392

05392

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02439
CERTIFICATE OF DEATH
02396

1. PLACE OF DEATH a. COUNTY <u>Montgomery County -</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 1b <u>4 mo.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				d. STREET ADDRESS <u>11518 Lovejoy St. Kensington Md</u>			
3. NAME OF DECEASED (Type or print) First <u>HARVEY</u> Middle <u>JAMES</u> Last <u>BAKER</u>				4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 15 1879</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>20</u> Days <u>19</u> Hours <u>66</u> Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Jacksonville, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpeniter - Railroad</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Jacksonville, Illinois</u>	
13. FATHER'S NAME <u>William Baker</u>				14. MOTHER'S MAIDEN NAME <u>ANNA CARRIE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>708-1298-39</u>		17. INFORMANT <u>Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> 491X DUE TO <u>Broncho pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>24 hrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sep. 1965</u> to <u>Feb 20, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 19, 1966</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert T. Thibadeau</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>				22d. ADDRESS <u>3920 FARRAGUT AVE KENS. MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>2-21-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>-</u>		23d. LOCATION (City, town or county) (State) <u>Jacksonville, Ill</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>FEB 25 1966</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02440

02397

<p>1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u> <u>Washington DC</u></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u></p>		<p>c. LENGTH OF STAY IN 1b <u>1 hr 45 m</u></p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16-2</u></p>			
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u></p>				<p>d. STREET ADDRESS <u>2420 Rochelle Ave</u></p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Balch</u></p>				<p>4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1966</u></p>			
<p>5. SEX <u>Female</u></p>		<p>6. COLOR OR RACE <u>Caucas.</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Feb. 2, 1966</u></p>	
<p>9. AGE (In years last birthday) yrs. <u>1</u></p>		<p>IF UNDER 1 YEAR Months <u>1</u> Days <u>45</u></p>		<p>IF UNDER 24 HRS. Hours <u>1</u> Min. <u>45</u></p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Maryland</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>Kenneth Balch</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Joyce Kube</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u></p>		<p>16. SOCIAL SECURITY NO. <u>none</u></p>		<p>17. INFORMANT <u>mother</u> Address</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>750X</u> DUE TO <u>Anencephalic newborn</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>750X</u> DUE TO <u>Anencephalic newborn</u> (c)</p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>							
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>2-2</u>, 19<u>66</u>, to <u>2-3</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>2-3</u>, 19<u>66</u>, and that death occurred at <u>12</u> M, from the causes and on the date stated above.</p>							
<p>22a. SIGNATURE <u>Alan W. Winchel</u></p>				<p>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.</p>		<p>22b. DATE SIGNED <u>2-4-66</u></p>	
<p>22c. PHYSICIAN'S NAME (Type) <u>ALAN W. WINCHEL MD</u></p>				<p>22d. ADDRESS <u>800 PERSHING DR. SS. MD</u></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE THEREOF <u>2/7/66</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u></p>	
<p>24. FUNERAL DIRECTOR <u>Tyson Wheeler 1331 Rockville Pike, Rock. Md.</u></p>				<p>25a. REC'D BY REGISTRAR <u>FEB 10 1966</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>	

05301

05301



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02441

02398

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North Chevy Chase</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>None</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North Chevy Chase</u> 15-1 d. STREET ADDRESS <u>8827 Kensington Pkwy</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>W</u> Middle <u>Ballard</u> Last		4. DATE OF DEATH Month <u>Feb</u> Day <u>16</u> Year <u>1966</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>8/30/1882</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Richard M Ballard</u>						14. MOTHER'S MAIDEN NAME <u>Sara Bradley</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u>458-03-4655</u>				17. INFORMANT <u>Rubie Baker</u> Address <u>8827 Kensington Pkwy North Chevy Chase, Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> 442X DUE TO (b) <u>Arteriosclerosis - cardio-vascular</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>renal disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Carcinoma of prostate. Prostatitis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>None</u>									
20c. TIME OF INJURY Month, Day, Year <u>None</u> 19 Hour a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>					
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> ^{to} <u>present</u> , that (I) (we) last saw the deceased alive on <u>1/27, 1966</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>John B. Umhan</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/16/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAN</u>						22d. ADDRESS <u>8805 Conn. Ave. Ch. Ch. Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-18-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Rockville Maryland</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u> ADDRESS <u>3101 Wisc. Ave NW, Washington DC</u>						25a. REC'D BY REGISTRAR <u>FEB 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02442 CERTIFICATE OF DEATH 02399											
1. PLACE OF DEATH a. COUNTY MONTGOMERY					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROCKVILLE						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL					d. STREET ADDRESS 4112 GREAT OAK ROAD			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VIRGINIA			Middle RIGGS		Last BARTLETT		4. DATE OF DEATH Month FEBRUARY		Day 9 Year 19 66		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-31-882		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 02 Days 23 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT WORKER		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HARRY RIGGS						14. MOTHER'S MAIDEN NAME LOUISA WOOD					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. None		17. INFORMANT HOSPITAL RECORDS			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DISSECTING ANEURYSM - ABDOMINAL 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) ATHEROSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 7 DAYS YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2-2 , 19 66 , to 2-9 , 19 66 , that (I) (we) last saw the deceased alive on 2-8 , 19 66 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.											
22a. SIGNATURE <i>Jack Schumacher</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 2-9-66		
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M.D.						22d. ADDRESS GAITHERSBURG, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-11-66		23c. NAME OF CEMETERY OR CREMATORY Rockville Union			23d. LOCATION (City, town or county) (State) Rockville, Md.			
24. FUNERAL DIRECTOR Francis H. Barber						ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR FEB 11 1966		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>	

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Rockville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02443

02400

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mohican Hills</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brook Grove Foundation (Sharon)</u>				d. STREET ADDRESS <u>5445 Mohican Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>V</u> Last <u>Beall</u>				4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1880</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>Nashville Tenn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>John Beall</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Passmore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Daughter</u> Address <u>Mrs. E.C. Barrington</u> <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>491X</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c) DUE TO (c) (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Smoking, Admitted after admission</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> e.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1, 1955</u> to <u>Feb 12, 1966</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> , 19 <u>66</u> , and that death occurred at <u>10</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>A.D. Bonifant</u>				22b. DATE SIGNED <u>2-12-66</u>		22c. PHYSICIAN'S NAME (Type) <u>A.D. BONIFANT</u>	
22d. ADDRESS <u>52nd St. S.W. Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-15-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>Bethesda, Maryland</u>				DATE <u>2-16-1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02444

02401

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 1 Hours			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MEGHAN Middle THERESA Last BECKER				4. DATE OF DEATH Month Feb. Day 3 Year 19 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/2/65	9. AGE (In years last birthday) yrs. 2 Months 1 Days 1 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		
10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Silver Spring, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME G. Louis Becker				14. MOTHER'S MAIDEN NAME Barbara L. Marino			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT G. Louis Becker	
18. ADDRESS 2711 Calgary Ave. Kensington, Md.							
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiorespiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary to asphyxiation in (c) crib, accidental							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Infant asphyxiated in crib.			
20c. TIME OF INJURY Month, Day, Year 2 15 p.m. 2-3 1966				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) (County) (State) Kensington Montgomery Md.							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22. ACTUAL SIGNATURE Belden R. Reap M.D.				22. DATE SIGNED Feb. 3, 1966			
EXAMINER'S NAME (Type) BELOEN R. REAP, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-5-66		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR FEB 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS 8434 Georgia Avenue Silver Spring, Md.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02445 CERTIFICATE OF DEATH 02442											
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 1 week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOLY CROSS HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 800 Patton Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) SAMUEL B BENNETT			4. DATE OF DEATH FEB. 25 1966		5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 9/7/06 9. AGE (in years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDITOR			10b. KIND OF BUSINESS OR INDUSTRY PUBLIC HOUSING ADM.		11. BIRTHPLACE (County & State, or foreign country) PA.			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Richard Dana Bennett			14. MOTHER'S MAIDEN NAME Virginia Butterworth		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						
16. SOCIAL SECURITY NO. 251-34-5025			17. INFORMANT Willis Bennett Address 4410 Chesapeake St. N.W., Washington, D.C.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute peritonitis and pancreatitis DUE TO (b) Status following modified Whipples procedure DUE TO (c) Carcinoma head of pancreas										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 2/24/1966 , to 2/25/1966 that (I) (we) last saw the deceased alive on 2/25/1966 , and that death occurred at 1531 A , from the causes and on the date stated above.											
22a. SIGNATURE Thomas G. Edison M.D.			22b. DATE SIGNED FEB 25 1966		22c. PHYSICIAN'S NAME (Type) Thomas G. Edison, M.D.						
22d. ADDRESS 1015 Spring St., Silver Spring, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Feb 28, 1966		23c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery		23d. LOCATION (City, town or county) (State) Fairland, Maryland				
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.			25a. REC'D BY REGISTRAR FEB 28 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge						

1012 Spring St., Silver Spring, Md.

Thomas G. Edison, N.D.

Dr. J. M. [illegible]

Dr. J. M. [illegible]

Dr. J. M. [illegible]

Dr. J. M. [illegible]

Dr. J. M. [illegible]

Carotid head of pancreas
procedure
Status following modified Whipple's
pancreatic and pancreaticitis

Dr. J. M. [illegible]

Dr. J. M. [illegible]

Dr. J. M. [illegible]

Dr. J. M. [illegible]

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Dr. J. M. [illegible]

Dr. J. M. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02446 CERTIFICATE OF DEATH 02403

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1015 DeBeck Drive</u>		d. STREET ADDRESS <u>1015 DeBeck Drive</u>	
3. NAME OF DECEASED (Type or print) <u>First PAULINE Middle P. Last BESSER</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1894</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown Peace</u>		14. MOTHER'S MAIDEN NAME <u>Laura Peace Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Georgia Ray--Cousin--Address above item #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Encephalomalacia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>December, 1963</u> , to <u>Feb. 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 9, 1966</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William Frank</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>Feb. 9, 1966</u>
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM FRANK, M.D.</u>		22d. ADDRESS <u>1125 ROCKVILLE PIKE, ROCKVILLE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2/12/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Rose Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>York, Pennsylvania</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		ADDRESS <u>1331 Rockville Pike, Rockville Maryland</u>	25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00250

00250



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02443

02404

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN Tb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanatorium				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville 16-2 d. STREET ADDRESS 2027 Rittenhouse Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Middle Last JACOB BLAFKIN (Type or print)			4. DATE OF DEATH Month Day Year Feb. 25, 1966 19				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/15/1888	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Owner (Ret)		10b. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (County & State, or foreign country) RUSSIA			
13. FATHER'S NAME Samuel Blafkin			14. MOTHER'S MAIDEN NAME Mollie				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Bess Blafkin Address same as 2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular accident DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Art. Hypertensive Ht. Dis. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 4 hrs. years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from March, 1960, to Feb 25, 1966, that (I) (we) last saw the deceased alive on Feb 25, 1966, and that death occurred at 10:30 PM, from causes and on the date stated above.							
22a. SIGNATURE Isidore Shulman			22b. DATE SIGNED 2-26-66		22c. PHYSICIAN'S NAME (Type) ISIDORE SHULMAN		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/27/66		23c. NAME OF CEMETERY OR CREMATORY Natl. Mem. Park		
24. FUNERAL DIRECTOR Goldberg Funeral Home			25a. REC'D BY REGISTRAR MAR 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		
23d. LOCATION (City or Town) Falls Church, Va. (County) (State)							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No. 02405

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 1 yr. 4½ Mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Potomac Valley Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence First Bonifant Middle Last		4. DATE OF DEATH Feb Month 5 Day 1966 Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1874
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 2 Days 14	IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Editor		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME James Bonifant	
14. MOTHER'S MAIDEN NAME Laura Craigen		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Unknown		INFORMANT Neice Mrs. Herbert Angel Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the <u>under-</u> lying cause lost. (c) Coronary Heart Disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH 1 day years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1 , 19 63 , to Feb , 19 66 that I last saw the deceased alive on Feb 1 , 19 66 , and that death occurred at 2:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James W. Egan		ADDRESS (Street, city or town, state) 5413 Cedar Lane Bethesda Maryland	
PHYSICIAN'S NAME (Type) JAMES W. EGAN		DATE SIGNED 2/5/66	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-7-66	22c. NAME OF CEMETERY OR CREMATORY Potomac Meth.Ch.Cem.	22d. LOCATION (City, town, or county) (State) Montgomery County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR FEB 14 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02449

CERTIFICATE OF DEATH

02406

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>15 days</u>		d. STREET ADDRESS <u>4421 Hallet Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lois James Boone</u>		4. DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-13-52</u>
9. AGE (In years last birthday) yrs. <u>6</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Durham, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Luth Garrett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Lloyd Boone-Husband-Jane</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u> 154X DUE TO (b) <u>Carcinoma of Rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-21</u> , 19 <u>66</u> to <u>2-4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-3</u> , 19 <u>66</u> , and that death occurred at <u>8:30</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Fredesrick B. Hartsock</u> M.D.		22b. DATE SIGNED <u>2-4-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Fredesrick B. Hartsock</u>		22d. ADDRESS <u>218 W. Main St. Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial-transit</u>	23b. DATE THEREOF <u>2/4/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Durham, North Carolina</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02450

02407

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4906 River Road		d. STREET ADDRESS 4906 River Road	
3. NAME OF DECEASED (Type or print) George A. Borresen		4. DATE OF DEATH Month February Day 22 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 22, 1884
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 11 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Peter N. Borresen		14. MOTHER'S MAIDEN NAME Mary Paulsen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFIRMANT Brother Harry Borreson		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Obesity		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atheromata Aorta, Carcinoma Prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2 April, 1965 to 22 Feb., 1966 , that (I) (we) last saw the deceased alive on 17 January 1966 , and that death occurred at 5 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Wm H. Beard		22b. DATE SIGNED 23 Feb. 66	
22c. PHYSICIAN'S NAME (Type) WILLIAM H. BEARD		22d. ADDRESS 2814 Conn. Ave., N.W., Washington, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-28-66	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE MAR 3 1966	

02830

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MEMORANDUM

Barbados

4008 River Road

4008 River Road

George A.

X-1000 22, 1964

Refined

1000 22, 1964

Robert H. Harrison

1000 22, 1964

Refined

NO

WILLIAM H. BRAND

214 Tenth Ave., N.W.

2-28-62

ROBERT A. HUNTER

1000 22, 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02451

CERTIFICATE OF DEATH

02408

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>4 years</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>8329 Grubb Road</i>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>8329 Grubb Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>GOLDIE</i> Middle <i>B.</i> Last <i>BOYER</i>			4. DATE OF DEATH Month <i>February</i> Day <i>23</i> Year <i>1966</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 1, 1891</i>	9. AGE (In years last birthday) <i>74</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Kansas City, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Harland Kitterman</i>			14. MOTHER'S MAIDEN NAME <i>Pet Silla</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Charles N. Boyer</i> Address <i>8329 Grubb Road, Silver Spring, Maryland</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Myocardial Infarction</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic cardiovascular disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>					INTERVAL BETWEEN ONSET AND DEATH <i>weeks</i> <i>Years</i>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept.</i> , 19 <i>61</i> , to <i>Feb. 23</i> , 1966, that (I) <i>we</i> last saw the deceased alive on <i>Feb 16</i> , 1966, and that death occurred at <i>10:30</i> PM, from the causes and on the date stated above.					
22a. SIGNATURE <i>Gene U. Cohen</i>			22b. DATE SIGNED <i>Feb 26, 1966</i>		
22c. PHYSICIAN'S NAME (Type) <i>Gene U. Cohen, M.D.</i>			22d. ADDRESS <i>1106 Spring Street, Silver Spring, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2-28-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Silver Spring, Maryland</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and finally event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 8, 9 Film G374 3/18/66 mh

CERTIFICATE OF DEATH

02452		02409	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
c. LENGTH OF STAY IN 1b <u>7 days</u>		d. STREET ADDRESS <u>2817 PARKER CT</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM E BOYER</u>		4. DATE OF DEATH Month Day Year <u>FEB 18 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1912 3-22-11</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM BOYER</u>		14. MOTHER'S MAIDEN NAME <u>MYRTLE BROWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>413-09-4509</u>	
17. INFORMANT <u>Wife - Margaret C. Larmer</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1621 Bronchial obstruction</u> DUE TO (b) <u>Me. ca. bronchogenic</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>Feb 17 1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>65</u> to <u>Feb</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Feb 17</u> , 19 <u>66</u> , and that death occurred at <u>3:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>V.C. Lefurman</u> M.D.		22b. DATE SIGNED <u>FEB 18, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>V.C. Lefurman</u>		22d. ADDRESS <u>1150 Connecticut Ave Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>21 FEB 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON VA.</u>
24. FUNERAL DIRECTOR <u>GINARDI FUNERAL HOME INC. 7400 GEORGIA AVE. N.W. DC 20012</u>		25a. REC'D BY REGISTRAR <u>FEB 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

00250

UNITED STATES

00250

Mr. C. F. Thompson
General of the
Frank

1120 Connecticut Ave NW
Feb 18, 1946
X
Feb 17, 1946
Feb 16, 1946
Feb 15, 1946

W.C. Thompson

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

02453

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02410

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emory Grove</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD. Garthersburg</u>		d. STREET ADDRESS <u>?</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Sylvester</u> Last <u>Braxton</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/1939</u>
9. AGE (In years last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR Months <u>26</u> Days <u>26</u> Hours <u>26</u> Min. <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Braxton</u>		14. MOTHER'S MAIDEN NAME <u>Ethel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic Pancreatitis</u> <u>3220</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute and Chronic Alcoholism</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u>		22. DATE SIGNED <u>2/1/66</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/4/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Emory Grove Montg. MD.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25. REC'D BY REGISTRAR <u>Feb 7 1966</u>	
ADDRESS <u>Rockville MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01890

6-23-57

STATE OF
NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02454

02411

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15-1 d. STREET ADDRESS <u>6215 Goldsboro Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Brady Boy "A" Briscoe</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>2-18-66</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) yrs. <u>2</u> 10. DATE OF DEATH <u>2-18-66</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mont. Co., Md.</u> 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME <u>Anthony Wellesley Briscoe</u> 14. MOTHER'S MAIDEN NAME <u>Zahava Goldfoot</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Father</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. 22a. SIGNATURE <u>Anna L. Van Rook</u> M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>2/23/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u> 23d. LOCATION (City or Town) (County) (State) <u>Bethesda - Montgomery - Md.</u> 24. FUNERAL DIRECTOR <u>Mrs. Amelia C. Carter</u> 25a. RECEIVED BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE ADDRESS <u>Administrative</u> DATE <u>FEB 28 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1150



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02455

02412

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6215 Goldsboro Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Betty Boy "B" Briscoe</u>		4. DATE OF DEATH <u>2-18</u> 19 <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years last birthday) yrs. <u>59</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Mont. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>-</u>	
13. FATHER'S NAME <u>Anthony Wellesley Briscoe</u>		14. MOTHER'S MAIDEN NAME <u>ZAHAVA Gold Foot</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Father</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>immaturity</u> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Anna M. Van Rooy</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>cremation</u>	<u>2/23/66</u>	<u>Suburban Hospital</u>	<u>Bethesda-Montgomery-Md.</u>
24. FUNERAL DIRECTOR <u>Mrs. Amelia C. Carter</u> Administrator (SEA)		25a. REC'D BY REGISTRAR DATE <u>FEB 28 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED BY DEPT.

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RECEIVED BY DEPT.
OF THE
NAVY
WASHINGTON, D.C.
JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02456

02413

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>83-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL HALL NURSING HOME</u>		d. STREET ADDRESS <u>1212 S. OAK CREST RD</u>	
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>BROOKS</u> Last <u>BROOKS</u>		4. DATE OF DEATH <u>FEBRUARY 3 1966</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 24 1890</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. FINDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET.-SCHOOL TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK STRUMBERGER</u>		14. MOTHER'S MAIDEN NAME <u>EVA MYERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>231-62-7868</u>	
17. INFORMANT <u>ETHEL B. YOUNG</u>		Address <u>5012-45th ST. N.W., D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL HEMORRHAGE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>DEC. 24, 1965</u> to <u>FEB 3, 1966</u> , that (I) (we) last saw the deceased alive on <u>FEB 3 1966</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>FEB 3, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>5206 N. ...</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-7-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>SUITLAND MD.</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>FEB 9 1966</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
02457 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>3-DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>				02414 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u> d. STREET ADDRESS <u>9809 Capitol View Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Brown</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1966</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 8, 1876</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired interior decorator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Decorating</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Forest Glen, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward Brown</u>						14. MOTHER'S MAIDEN NAME <u>Cissel</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT <u>Alger Y. Barbee</u> Address <u>9809 Capitol View Avenue Silver Spring, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Genualy & Arterio Sclerosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1956</u> to <u>Feb 1, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 1, 1966</u> , and that death occurred at <u>7:42</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>W. B. Wardrop</u>						22b. DATE SIGNED <u>2/2/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>W. B. Wardrop</u>						22d. ADDRESS <u>800 Pershing Drive, Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-4-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville Maryland</u>					
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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3-14-42

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Montgomery									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillandale					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillandale									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1766 Overlook Drive					d. STREET ADDRESS 1766 Overlook Drive									
3. NAME OF DECEASED (Type or print) First Eva Middle Luella Last Brown					4. DATE OF DEATH February 14 19 66									
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/7/71		9. AGE (In years last birthday) 95						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.		10c. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
13. FATHER'S NAME Limon D. Sabin					14. MOTHER'S MAIDEN NAME Susan Dexter									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no					16. SOCIAL SECURITY NO. -----					17. INFORMANT Luella V. Miles same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aorta 451X due to Aneurysm Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (a), stating the underlying cause last. due to (c) Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 1 day ?				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town)					20g. (County)					20h. (State)				
21. I certify that (I) (this hospital) attended the deceased from 1953 to 1/4 Feb , 19 66 that (I) (<u>we</u>) last saw the deceased alive on 12 Feb 1966 , and that death occurred at 4:10 PM on the causes and on the date stated above.														
22a. SIGNATURE William D. Aud					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 2/14/66				
22c. PHYSICIAN'S NAME (Type) William D. Aud					22d. ADDRESS 9006 Colesville Rd. S.S. Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation					23b. DATE THEREOF 2/17/66					23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory Prince Georges County, Md.				
24 FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.					ADDRESS 2901 14th St. N.W. Washington, D.C.					25a. REC'D BY REGISTRAR Feb 16 1966				
										25b. REGISTRAR'S SIGNATURE Charles Judge				

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02459

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02416

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>35 minutes</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitorium and Hospital</u>		d. STREET ADDRESS <u>9123 Dunbar Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Kelly</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Dec 1929</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman, P.G. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Ralph W Brown</u>		14. MOTHER'S MAIDEN NAME <u>Cordelia C. Heffner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>578 42 7078</u>	
17. INFORMANT Address <u>Mary E Brown Landover, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforating gun shot wound of chest</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot by assailant during attempt to serve a warrant.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>4:15 p.m.</u> <u>2</u> <u>19</u> <u>66</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Apartment building 2211 University Blvd.</u>		20f. (City or town) <u>Langley Park, P.G. Md.</u> (County) <u>P.G.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u>		22. DATE SIGNED <u>2-20-66.</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 23, 1966</u>	
23c. NAME OF CEMETERY OR <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u>	
24. FUNERAL DIRECTOR ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 23 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03128

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER - DEPARTMENT OF HEALTH
STATISTICAL SECTION AND RECORDS SECTION
BOSTON

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER - DEPARTMENT OF HEALTH
STATISTICAL SECTION AND RECORDS SECTION
BOSTON

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STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER - DEPARTMENT OF HEALTH
STATISTICAL SECTION AND RECORDS SECTION
BOSTON

cleaned & Medical Examined

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>9 hrs 25 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SAN. Hosp</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>8115 THOREAU DR 15-1</u> d. STREET ADDRESS <u>BETHESDA</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Tillie</u> Middle <u>C</u> Last <u>BROWN</u>					4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1966</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-6-14</u>		9. AGE (In years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR: Months <u>51</u> Days <u>12</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM CAFRITZ</u>					14. MOTHER'S MAIDEN NAME <u>IDA ROSLOFSKY</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>PTS. RECORD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage -</u> <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential hypertension</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u> <u>1945</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>9:55 a.m.</u> <u>2/12 1966</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , to <u>2/12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/12</u> 19 <u>66</u> , and that death occurred at <u>9:55</u> P.M., from the causes and on the date stated above.									
22a. SIGNATURE <u>Herbert Wechsler</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		22b. DATE SIGNED <u>2/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Herbert Wechsler</u>						22d. ADDRESS <u>1800 Eye St. N.W. Wash. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-14-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>B'nai Israel Cem.</u>		23d. LOCATION (City, town or county) (State) <u>OXON HILL, MD.</u>			
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		ADDRESS <u>4217-9th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>FEB 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

11/17

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7/11/10 C 11/17

10 Jan 1995
General Services
Department of Defense

1200 EYE ST NW, WASHINGTON DC 20004
HARBOUR WATCH
2/1/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 02461 CERTIFICATE OF DEATH 02418									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS Silver Spring, Md.</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>109 ST. LAWRENCE DR.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>JOSEPH PAUL BROWNE</u> First Middle Last					4. DATE OF DEATH <u>2</u> <u>17</u> <u>1966</u> Month Day Year				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-25-98</u> yrs.		9. AGE (In years last birthday) <u>68</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Admr. J.C.A.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Martin Browne</u>					14. MOTHER'S MAIDEN NAME <u>Mary Honley</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>217-42-8429</u>		17. INFORMANT <u>Dorothy Browne</u> Address <u>109 Lawrence Dr. Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>about 6 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>16 Feb 1966</u> , to <u>17 Feb 1966</u> , that (I) (we) last saw the deceased alive on <u>16 Feb 1966</u> , and that death occurred at <u>175 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>William D. And</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/17/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>William D. And</u>					22d. ADDRESS <u>9006 Colville Rd., Silver Spring, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 21 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington, Va.</u>		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		Address <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02462

02419

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring			
c. LENGTH OF STAY IN 1b 15-1				d. STREET ADDRESS 216 Leighton Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HAROLD LEON BUCKLEY				4. DATE OF DEATH Month February Day 8 Year 1966			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-6-12	
9. AGE (in years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 0 Hours 0 Min. 0		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAINING SUPERVISOR D.C. TRANSIT		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME RUSH Buckley		14. MOTHER'S MAIDEN NAME Ellen Wilkes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-10-5977		17. INFORMANT Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 330X DUE TO (b) Ruptured cerebral aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 2/4 , 19 66 to 2/8 , 19 66 , that (I) (we) last saw the deceased alive on 2/8 , 19 66 , and that death occurred at 4:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE R.A. Mendelsohn				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/8	
22c. PHYSICIAN'S NAME (Type) R.A. MENDELSON				22d. ADDRESS 1015 SPRING ST. SILVER SPRING MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/11/66		23c. NAME OF CEMETERY OR CREMATORY NATL. MEMO. PARK		23d. LOCATION (City, town or county) (State) FALLS CHURCH VA.	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO				25a. REC'D BY REGISTRAR 8623 GR. AVE. FEB 14 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Mr. W. C. Mead

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Cleared by Dr. King

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1 (M)

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02463 CERTIFICATE OF DEATH 02420

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1500 E. Forest / Glen / Rd. / 8310 16th Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carl Lewis Buehl</u>		4. DATE OF DEATH <u>February 1, 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired credit manager Goodyear Tire</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Doylestown, Ohio</u>
13. FATHER'S NAME <u>Louis J. Buehl</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>291-03-7652</u>	17. INFORMANT <u>J. E. Melville</u> Address <u>3706 Heather Court Alexandria, Virginia</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROSIS, GENERALIZED</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> <u>10 YEARS</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19 <u> </u> , to <u>Jan. 31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan. 21</u> , 19 <u>66</u> , and that death occurred at <u>4:00</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Philip R. James</u>		22b. DATE SIGNED <u>2-1-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip R. James</u>		22d. ADDRESS <u>Washington Clinic</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 3, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		DATE <u>FEB 7 1966</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02464

02421

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3000 McComas Ave Kensington Gardens Sanitarium</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>47-3</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>923 Kennedy St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Pauline Thomason Burns</u>		4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>1966</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>3/31/91</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired school teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Emil M. Thomasson</u>			14. MOTHER'S MAIDEN NAME <u>Catherine Walstedt</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-66-1748</u>		17. INFORMANT <u>Home Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Hypertensive Nephroses</u> 2040 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>16 months</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>March 12, 1965</u> to <u>March 11, 1966</u>, that (I) (we) last saw the deceased alive on <u>March 11, 1966</u>, and that death occurred at <u>10:28 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel T. Kimble</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-12-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u>		22d. ADDRESS <u>927 Pinesburg Dr., Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>2/15/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>		23d. LOCATION (City, town or county) (State)			
24 FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>2901 14th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 16 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02465					CERTIFICATE OF DEATH					02422				
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8313 Old Georgetown Road					d. STREET ADDRESS 8313 Old Georgetown Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) AUBREY LEWIS BURRUSS, Jr.					4. DATE OF DEATH Feb. 21, 19 66									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 9, 1925		9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Apprentice-Electrician				10b. KIND OF BUSINESS OR INDUSTRY Electrical		11. BIRTHPLACE (County & State, or foreign country) Richmond, Virginia			12. CITIZEN OF WHAT COUNTRY? U. S.					
13. FATHER'S NAME Aubrey L. Burruss, Sr.					14. MOTHER'S MAIDEN NAME Katharine Elizabeth Toms									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes.			16. SOCIAL SECURITY NO. WW II		17. INFORMANT Mother Address Katharine E. Toms			Same as Item 2.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA BOTH 163X DUE TO LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH 3 MONTH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from 12/29, 1965 to 2/21, 1966 , that (I) (we) last saw the deceased alive on 2/10, 1966 , and that death occurred at 8A M, from the causes and on the date stated above.														
22a. SIGNATURE 								22b. DATE SIGNED 2-21-66						
22c. PHYSICIAN'S NAME (Type) LEO I. DONOVAN				22d. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-66		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery				23d. LOCATION (City, town or county) (State) Arlington, Virginia						
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR FEB 24 1966		25b. REGISTRAR'S SIGNATURE 						

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VR A15 (4)
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02422

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holy Cross Hosp.</i>		d. STREET ADDRESS <i>1109 Caddington Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>David Anthony Cameron</i>		4. DATE OF DEATH <i>2 19 1966</i>		5. SEX <i>M</i>	
6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 21, 1894</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unemployed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (County & State, or foreign country) <i>PENNSYLVANIA</i>	
13. FATHER'S NAME <i>Edward W. Cameron</i>		14. MOTHER'S MAIDEN NAME <i>Agnes B. Hendenberry</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Marie F. Ben</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO (b) <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 13, 1966</i> , to <i>Feb 19, 1966</i> , that (I) (we) last saw the deceased alive on <i>Feb 19, 1966</i> , and that death occurred at <i>1:25 PM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Donald W. Datlow</i>		22b. DATE SIGNED <i>Feb 19, 1966</i>		22c. PHYSICIAN'S NAME (Type) <i>DONALD W. DATLOW, M.D.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Feb. 22, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Patricks Cemetery</i>	
23d. LOCATION (City, town or county) (State) <i>Norristown, Pennsylvania</i>		24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc</i>		25a. REC'D BY REGISTRAR <i>FEB 23 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25d. DATE <i>FEB 23 1966</i>	

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Handwritten notes, possibly a list or address, including "Silver Spring" and "Holt".

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02467

02424

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 1/2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Congressional Manor Sanitarium</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1411 Rockville Pike</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Boyle</u> Last <u>Campbell</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 21-1879</u> 9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>			
13. FATHER'S NAME <u>St. John Boyle</u>			14. MOTHER'S MAIDEN NAME <u>Anna McKinley</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Wm. H. Collins (Atty)</u> <u>426 Shoreham Bldg. Washington 9, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>18 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Congestive Heart Failure</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1960</u> to <u>Feb. 15</u>, 1966, that (I) (we) last saw the deceased alive on <u>Feb. 15</u>, 1966, and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph H. Watson</u>			22b. DATE SIGNED <u>2-15-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Joseph H. Watson</u>			22d. ADDRESS <u>3201 Wisconsin Ave.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>2/16/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cem.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>FEB 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02468		02425	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 22 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie d. STREET ADDRESS 3102 Shield Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Ernest Campbell First Middle Last 4. DATE OF DEATH February 6 1966 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 26 September 1956 9. AGE (In years last birthday) 9 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 10b. KIND OF BUSINESS OR INDUSTRY --- 11. BIRTHPLACE (County & State, or foreign country) Wisconsin 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Campbell 14. MOTHER'S MAIDEN NAME Mary Skarakis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas meningitis and meningeal leukemia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphocytic leukemia DUE TO (c) 3 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 15 January , 19 66 , to 6 February 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6 February 19 66 , and that death occurred at 7:55 M. from the causes and on the date stated above.			
22a. SIGNATURE Herman A. Godwin, Jr. 22c. PHYSICIAN'S NAME (Type) Herman A. Godwin, Jr., M.D.		22b. DATE SIGNED 6 February 1966 22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 2-8-1966	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City, town or county) (State) Bladensburg Maryland	
24. FUNERAL DIRECTOR W. W. Chambers Co		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE DATE FEB 10 1966	

MEDICAL CERTIFICATION

02482

02482

Place of birth

Marion

Occupation

Route

22 Days

Detention

302 St. Louis

The Clinical Center, Bethesda, Md.

February 6

Campbell

Ernest

William

23 September 1950

White

Male

USA

Wisconsin

Student

St. Stanislaus

Clinical Center

The National Record

The Clinical Center, Bethesda, Md.

None

to

2 years

Intermittent neurological and psychiatric symptoms

Adult's lymphocytic leukemia

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The Clinical Center, National

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The Clinical Center, Bethesda, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROCKVILLE c. LENGTH OF STAY IN 1b 2 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) POTOMAC VALLEY NURSING Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA d. STREET ADDRESS 9509 LINDALE DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY First Middle Last 4. DATE OF DEATH 2 Month 18 Day 19 Year 66		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2-June-1884 9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR Months 8 Days 16 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Illinois 12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Matej Drije 14. MOTHER'S MAIDEN NAME Anna (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Son Leslie J. Capek Address Same as Item 2.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 1966 to 2-18 , 1966 that (I) (we) last saw the deceased alive on 1/24 1966 and that death occurred at 10:30 M, from the causes and on the date stated above. 22a. SIGNATURE Paul D. Cantor 22b. DATE SIGNED 2-18-66 22c. PHYSICIAN'S NAME (Type) PAUL D. CANTOR 22d. ADDRESS 4709 Montgomery Lane Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 2-18-66 23b. DATE THEREOF 2-18-66 23c. NAME OF CEMETERY OR CREMATORY Bohemian Natl Cemetery 23d. LOCATION (City, town or county) (State) Chicago, Illinois		24. FUNERAL DIRECTOR ROBERT A. PUMPHREY ADDRESS Bethesda, Maryland 25a. REC'D BY REGISTRAR FEB 21 1966 25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>8 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. & Hosp. Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9310 Colesville Rd.</u>				9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hermon (Loma) Carter</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1966</u>				5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-10-'78</u> 9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months <u>25</u> Days <u>15</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>15</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Store business</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>David Carter</u> 14. MOTHER'S MAIDEN NAME <u>Tibby</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>294-07-5750</u> 17. INFORMANT <u>Washington San. & Hosp. Records - Takoma Park</u> Address <u>Takoma Park</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Congestive Heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterior and Posterior Cardiac infarcts</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u> <u>3 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 14</u> , 19 <u>62</u> , to <u>Feb 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 24</u> , 19 <u>66</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>John N. Andrews</u>				22b. DATE SIGNED <u>Feb. 25-66</u>				22c. PHYSICIAN'S NAME (Type) <u>John N. Andrews</u> 22d. ADDRESS <u>4601 Colesville Rd Silver Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/1/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>NATL MEMO PARK</u> 23d. LOCATION (City, town or county) (State) <u>Falls Church, VA.</u>				24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, Inc</u> ADDRESS <u>514 S. 5th St. MD</u> 25a. REC'D BY REGISTRAR <u>MAR 2 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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CENTINQUE OF DEATH

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[Faint, mostly illegible handwriting covering the main body of the page, possibly a list or journal entry.]

[Faint, mostly illegible handwriting along the right margin, possibly a continuation of the list or journal entry.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02471

02428

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bermantown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>Box 126 Berryville Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Patrick Barber Alan Carter</u>				4. DATE OF DEATH Month <u>2</u> Day <u>16</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-66</u>	9. AGE (In years last birthday) yrs. <u>32</u>	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Delmare Carter</u>				14. MOTHER'S MAIEN NAME <u>Evelyn Kathryn Streaan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Birth Certificate</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. OATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>7625</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Prematurity</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO OATH BUT NOT RELATED TO THE TERMINAL OISEASE CONOITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIOENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. OESCRIBE HOW INJURY OCCUREO. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-14</u> , 19 <u>66</u> , to <u>2-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-16</u> , 19 <u>66</u> , and that death occurred at <u>12:45</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph A. Dugan</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. OATE SIGNED <u>2/17/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph A. Dugan</u>				22d. ADDRESS <u>Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>		23d. LOCATION (City, town or county) (State) <u>Laytonsville, Md.</u>	
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>				25a. REC'D BY REGISTRAR <u>FEB 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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USA

Bethesda, Md.

Bethesda, Md.

Joseph A. Hogan

Laytonville, Md.

Laytonville

2-18-66

trial

Francis H. Barber Laytonville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02472

02429

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda 12 yrs. c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9600 Forest Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland Montgomery b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda 15 - 1 d. STREET ADDRESS 9600 Forest Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Catharine First Middle Last 5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH April 8, 1893 9. AGE (In years last birthday) 72 yrs. 10. IF UNDER 1 YEAR Months 10 Days 15 Hours 19 Min. 11. BIRTHPLACE (County & State, or foreign country) St. Louis, MO 12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Denis Cavanaugh 14. MOTHER'S MAIDEN NAME Mary Ann Foran 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT Ursaline Convent Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE DUE TO (b) CORONARY ARTERY DISEASE DUE TO (c) ARTERIO SCLEROTIC HEART DISEASE CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA (R) BREAST 10+ YEARS 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) D.A.A. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from MARCH, 1953 to FEBRUARY, 1966 , that (I) (we) last saw the deceased alive on FEBRUARY 19, 1966 , and that death occurred at 6 A.M. from the causes and on the date stated above. 22a. SIGNATURE Charles Savarese, M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) CHARLES SAVARESE, M.D. 22d. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 22b. DATE SIGNED 2/23/66 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/26/66 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery 23d. LOCATION (City, town or county) (State) Washington, D.C. 24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY BETHESDA, MD 25a. REC'D BY REGISTRAR DATE MAR 2 1966 25b. REGISTRAR'S SIGNATURE Charles Judge							

MEDICAL CERTIFICATION

02478

02478

Montgomery

Montgomery

Montgomery

Beckwith

Beckwith

12 yrs.

9000 Forest Road

9000 Forest Road

February 28 00

19 13

Education

9000 Forest Road
St. Mary's Convent Beckwith, Maryland

None

Adult 2126/40 Mr. Oliver Cemetery Washington, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02473
02430
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf	
c. LENGTH OF STAY IN ID 93 Days		d. STREET ADDRESS Box 257, Route #1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.			
3. NAME OF DECEASED (Type or print) First Mary Middle Ann Last Chapman		4. DATE OF DEATH Month February Day 23 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 November 1942
9. AGE (In years last birthday) 23 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Typist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Chapman		14. MOTHER'S MAIDEN NAME Mary Jennifer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-40-6596	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram-negative Septicemia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Acute Lymphocytic Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 17 hours 20 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from 22 November, 19 65 to 23 February 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 23 February 19 66 , and that death occurred at 12:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James H. Wells		22b. DATE SIGNED 23 February 1966	
22c. PHYSICIAN'S NAME (Type) James H. Wells, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-26-66	
23c. NAME OF CEMETERY OR CREMATORY ST. MARYS		23d. LOCATION (City, town or county) (State) BRANTOWN Md	
24. FUNERAL DIRECTOR HUNTT FUNERAL HOME		25a. REC'D BY REGISTRAR FEB 28 1966	
ADDRESS WALDORF MD		25b. REGISTRAR'S SIGNATURE Charles Judge	

0243

0243



TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page. It appears to contain a memorandum format with fields for TO, FROM, SUBJECT, and a body of text.]

FOR STATE HEALTH DEPT.

02474

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02431

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>23 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>Chester</u>		4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1880</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>UnKnown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-34-7281</u>	
17. INFORMANT <u>Patient's chart, admission record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism, secondary to fracture,</u> <u>9030</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>right femur, due to fall</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased became dizzy and fell from chair to floor</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:00</u> <u>1/26</u> <u>1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Kensington</u> (County) <u>Montg.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap, M.D.</u>		22. DATE SIGNED <u>Febr. 28, 1966</u>	
EXAMINER'S NAME (Type) <u>Belden R. Reap, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/3/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) <u>Suitland</u> (County) <u>Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>Bethesda, Md.</u>		DATE <u>MAR 3 1966</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and on or before the event within 72 hours after death.

1607

1723

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Garrett</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> d. STREET ADDRESS <u>Box 265 Rt #2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Sally</u> Middle <u>Loce</u> Last <u>Christian</u>						4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>1966</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-3-1903</u>		9. AGE (In years last birthday) <u>62</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Walter Arnold</u>						14. MOTHER'S MAIDEN NAME <u>Minnie Carroll</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkins disease</u> <u>201X</u> (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that (I) (this hospital) attended the deceased from <u>2/9/66</u>, 19<u>66</u>, to <u>2/13</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>2/13</u>, 19<u>66</u>, and that death occurred at <u>4:25</u> P.M., from the causes and on the date stated above.																	
22a. SIGNATURE <u>Raymond O. Ues</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-16-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sanage Cemetery</u>		23d. LOCATION (City, town or county) <u>Sanage Md.</u> (State)											
24. FUNERAL DIRECTOR <u>DeWitt Donaldson</u>						ADDRESS <u>Laurel, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE							
<u>W. Hammer</u>						DATE <u>FEB 28 1966</u>											

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02433

1
FOR STATE
HEALTH DEPT.

02476

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8100 Takoma Drive</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Jessie May Clark</u>		4. DATE OF DEATH <u>2 - 15 1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>09 6-17-1901</u>		9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Blair Thomas</u>				14. MOTHER'S M maiden NAME <u>Nellie May Howard</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes give war or dates of service)					
16. SOCIAL SECURITY NO. <u>578-26-8455</u>				17. INFORMANT <u>Mrs. Russell Brigham</u> Address <u>1034 Univ. Blvd. Hospital Road Silver Spring, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Acute coronary insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery heart disease</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>2-16-1966</u>					
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-18-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Clark E. Warner</u> ADDRESS <u>434 Georgia Avenue</u>				25a. REC'D BY REGISTRAR <u>FEB 18 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
Warner E. Pumphrey, Inc. Silver Spring, Md.													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1858

RECEIVED BY THE MEDICAL DEPARTMENT

02430

RECEIVED BY THE MEDICAL DEPARTMENT

[Faint, mostly illegible handwritten text, possibly a medical report or list, with some visible words like "Patient", "History", and "Examination".]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02477					02434				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>4 days</u>		a. STATE <u>D.C.</u>		b. COUNTY
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				
3. NAME OF DECEASED (Type or print) <u>Ellen P. Cokas</u>					d. STREET ADDRESS <u>706 New Jersey Avenue N.W.</u>				
4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1966</u>		5. SEX <u>Female</u>			6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-7-19</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>George Panopoulos</u>					14. MOTHER'S MAIDEN NAME <u>Mary Zuras</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Records - Washington Sanp Hospital</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>1538</u> DUE TO (b) <u>Ca of Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>1pm</u> <u>1966</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 6</u> , 19 <u>66</u> , to <u>Feb 10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 2-10</u> 19 <u>66</u> , and that death occurred at <u>1pm</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Raymond O. West</u>					22b. DATE SIGNED <u>2-10-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>					22d. ADDRESS <u>7600 Carroll Avenue, Takoma Park, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/14/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR <u>The S. H. Hines Co.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>				
24b. ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02478											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sen. & Co. Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8712 Cokesville Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Carrie Ruth Coleman</u>			First Middle Last			4. DATE OF DEATH <u>Feb 25 1966</u>			Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-27-15</u>		9. AGE (In years last birthday) <u>50 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary American Instrument Co.</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wilcox Barker</u>						14. MOTHER'S MAIDEN NAME <u>Jennie McNeil</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Harry Barker 407 Hilltop Drive Washington D.C.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ADENOCARCINOMA OF BREAST</u> DUE TO (c) <u>HOSE</u> INTERVAL BETWEEN ONSET AND DEATH <u>HOSE</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>FEB. 11, 1966</u> , to <u>FEB 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>FEB 25 1966</u> , and that death occurred at <u>933 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Albert H. Grollman</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/26/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN MD</u>						22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3-1-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Deer Creek Harmony Presbyterian Ch.</u>			23d. LOCATION (City, town or county) (State) <u>Darlington Md.</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 3 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

26/50

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1-1-50
The following is a list of the names of the persons who have been
admitted to the membership of the Society since the last meeting.
The names are given in alphabetical order.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02479					02436				
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Garrett Park			c. LENGTH OF STAY IN 1b MARYLAND		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Garrett Park				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5017 Euclid Street					d. STREET ADDRESS 5017 Euclid Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stuart		First H.		Middle Conover		4. DATE OF DEATH February 23 1966		Day 23 Year 1966	
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/5/1912		9. AGE (in years last birthday) 53 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 18 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Sales		11. BIRTHPLACE (County & State, or foreign country) New Jersey			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lemuel C. Conover					14. MOTHER'S MAIDEN NAME Elizabeth Darnell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16. SOCIAL SECURITY NO. unknown		17. INFORMANT 5017 Euclid St. Mrs. Dorothy B. Conover Garrett Pk, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 5 Mos. Unknown	
								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 1958 , to Feb 23 1966 , that (I) (we) last saw the deceased alive on Feb 21 1966 , and that death occurred at 3:00 PM , from the causes and on the date stated above.									
22a. SIGNATURE George Sharpe					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) George Sharpe, M.D.					22d. ADDRESS 10511 Summit Ave., Kensington, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 2/25/66			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Pleasantville Cem.			23d. LOCATION (City, town or county) (State) Pleasantville, N.J.	
24. FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Md.					25a. REC'D BY REGISTRAR FEB 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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Non-Exempt

General Fund

2017 Budget

2017 Budget

2017 Budget

2017 Budget

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
02480 1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hospital</u>						02437 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Langley Park, Md.</u> 16-2 d. STREET ADDRESS <u>1404 Merrimac Dr. Montgomery County</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Susanna K. CORADETTI</u>			4. DATE OF DEATH <u>Feb 27 1966</u>			5. SEX <u>F.</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>4-9-1915</u>			9. AGE (In years last birthday) <u>90</u> yrs.			10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Am</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>American</u>						13. FATHER'S NAME <u>JOHN KARNAY</u>			14. MOTHER'S MAIDEN NAME <u>ANN PADDEN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>220-44-499</u>			17. INFORMANT <u>FRANK CORADETTI</u> Address <u>5934 27th Ave NW 20031 SE</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, right</u> <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2/23</u> , 19 <u>66</u> , to <u>2/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/27</u> , 19 <u>66</u> , and that death occurred at <u>4:34</u> A.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>William F. Simpson</u>						22b. DATE SIGNED <u>2/27/66</u>			22c. PHYSICIAN'S NAME (Type) <u>William F. Simpson</u>		
22d. ADDRESS <u>6216 N.H. Ave NE - DC.</u>						23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Mar 2, 1966</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>						23d. LOCATION (City, town or county) (State) <u>Wheaton, Md</u>			24. FUNERAL DIRECTOR <u>W.W. Taltavull</u> ADDRESS <u>3603-18th NW D.C.</u>		
25a. REC'D BY REGISTRAR <u>MAR 1 1966</u>						25b. REGISTRAR'S SIGNATURE <u>J. C. Judge</u>					

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Feb 27 1962

James K. Cameron

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James K. Cameron

Mr. Cameron

Mr. Cameron

James K. Cameron

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James K. Cameron

James K. Cameron

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02481

02438

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase 15-1</u>			
c. LENGTH OF STAY IN 1b <u>50 hrs</u>				d. STREET ADDRESS <u>4700 Bradley Blvd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>J</u> Last <u>Crawford</u>				4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11/3/90</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George J. Nash</u>				14. MOTHER'S MAIDEN NAME <u>Ella Caggins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-30-0240</u>		17. INFORMANT <u>Ethel L. Butler</u> Address <u>same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic CARCINOMA</u> DUE TO <u>1621</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE, ART. C-VASCULAR DISEASE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1</u> , 19 <u>65</u> , to <u>2-9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-9</u> 19 <u>66</u> , and that death occurred at <u>9:40 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Edward W. Youngblood</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-10-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD W. YOUNGBLOOD</u>				22d. ADDRESS <u>WASHINGTON CLINIC, WASHINGTON 15, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/12/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Punchrey</u> ADDRESS <u>Bethesda, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02482

CERTIFICATE OF DEATH

02439

1. PLACE OF DEATH a. COUNTY Montgomery County Holy Cross Hosp. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spr., Montgomery Coun. c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Silver Spring b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Maryland Silver Spring, Maryland d. STREET ADDRESS 8201 16th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harry First Cutler Middle Last				4. DATE OF DEATH Feb Month 25 Day 19 Year 66			
5. SEX m		6. COLOR OR RACE w		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/10/89	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 7 Days 15		IF UNDER 24 HRS. Hours 15 Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Liquor Dealer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Abraham Cutler			
14. MOTHER'S MAIDEN NAME Sarah ---				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. 577-48-1695				17. INFORMANT Mrs. Jean Binder Address S. S., Md. 8503 Leonard Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Acute Coronary Occlusion Spks DUE TO (c) Coronary Atherosclerosis 16 yr PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 min							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 19, 1966 to Feb 24, 1966 , that (I) (we) last saw the deceased alive on Feb 21, 1966 , and that death occurred at 124 M , from the causes and on the date stated above.							
22a. SIGNATURE Benjamin Manchester				22b. DATE SIGNED 2-25-66		22c. PHYSICIAN'S NAME (Type) BENJAMIN MANCHESTER	
22d. ADDRESS 3200-16 St N. W.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/27/66		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon		23d. LOCATION (City, town or county) (State) Hyattsville, Maryland	
24. FUNERAL DIRECTOR B. DANZANSKY & SONS				25a. REG'D. BY REGISTRAR FEB 28 1966			
25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP Coronary Autopsy will be performed

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02483

02440

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wheaton Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47-3 d. STREET ADDRESS <u>3128 Patterson Pl. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>H</u> Last <u>DEATLEY</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>14</u> Year <u>1966</u>		5. SEX <u>F</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12 1890</u>			
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Lawrence DeAtley</u> Address <u>5210 Gretchen Street Kensington, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> DUE TO <u>arterio-sclerotic heart disease -</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>2-7</u> , 19 <u>66</u> , to <u>2-14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-14</u> , 19 <u>66</u> , and that death occurred at <u>1:54</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>2-14-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>E H Markwood</u>				22d. ADDRESS <u>3208-17th NW Wash. DC. 20010</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 2/17/66</u>		23b. DATE THEREOF <u>2/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maysville Cemetery</u>			
23d. LOCATION (City, town or county) <u>Maysville, Kentucky</u>		(State) <u> </u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> Address <u>Bethesda, Md.</u>			
25a. REC'D BY REGISTRAR <u>FEB 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08410

CRIMINALS OF DOUBT

2122

1

THE
STATE
OF
NEW
YORK
IN SENATE,
January 10, 1914.
REPORT
OF THE
COMMISSIONER
OF THE
DEPARTMENT
OF CORRECTIONS,
IN RESPONSE
TO A RESOLUTION
PASSED BY THE
SENATE, MAY 1, 1913.
ALBANY:
J. B. LEECH, JR.,
PRINTERS,
1914.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02484

02441

1. PLACE OF DEATH a. COUNTY Mont. Co. MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Mont. Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 24 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 223 E. Montgomery Ave.			d. STREET ADDRESS 9. North Adams St.		
3. NAME OF DECEASED (Type or print) First Middle Last Raymond S. Dodson			4. DATE OF DEATH Month Day Year Feb. 22 19 66		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/5/19	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) Surveyor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME George W. Dodson			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			14. MOTHER'S MAIDEN NAME Sasha Alice Williams		
16. SOCIAL SECURITY NO. 230-14-5087			17. INFORMANT Address Brother Wm. A. Dodson		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Bronchopneumonia DUE TO (b) 1 week Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis, liver, severe					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John S. Ball		22. DATE SIGNED 2/23/66		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-66	23c. NAME OF CEMETERY OR CREMATORY Fairfields Bapth. Cemetery		23d. LOCATION (City or Town) (County) (State) Burgess, North'd., Va.
24. FUNERAL DIRECTOR James Ash Funeral Home		ADDRESS Rainswood, Va.		25a. REC'D BY REGISTRAR DATE FEB 25 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

125

2010



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02485

CERTIFICATE OF DEATH

02443

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>75-3</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>			c. LENGTH OF STAY in 1b <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McKnights Town</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Hickok</u> Last <u>Drum</u>				4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>19 66</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 27, 1892</u>		
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hillard Hickok</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cronestier</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Charles H. Drum</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinoma, site unknown--</u> <u>163 X</u> DUE TO <u>Suspected lung.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u> </u> (c) DUE TO <u> </u>							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <u> </u> (this hospital) attended the deceased from <u>Jan. 19</u> , 19 <u>66</u> , to <u>Feb. 5</u> , 19 <u>66</u> , that <u> </u> (we) last saw the deceased alive on <u>Feb. 5</u> , 19 <u>66</u> , and that death occurred at <u>4:45</u> M, from causes on and on the date stated above.								
22a. SIGNATURE <u>J. B. EMERY</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Feb. 5, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>J. B. EMERY LT MC USN</u>				22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 7, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Gettysburg, Pennsylvania</u>		
24. FUNERAL DIRECTOR <u>Bender, Gettysburg, Pennsylvania</u>				25a. REC'D BY REGISTRAR <u>FEB 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

04430

DEPARTMENT OF DEFENSE

05182

1. NAME (Last, First, Middle Initial)		2. GRADE		3. TITLE	
4. ORGANIZATION		5. ADDRESS		6. CITY	
7. STATE		8. ZIP CODE		9. COUNTRY	
10. TELEPHONE		11. FAX		12. E-MAIL	
13. DATE		14. TIME		15. SIGNATURE	
16. PRINTED NAME		17. PRINTED GRADE		18. PRINTED TITLE	
19. PRINTED ORGANIZATION		20. PRINTED ADDRESS		21. PRINTED CITY	
22. PRINTED STATE		23. PRINTED ZIP CODE		24. PRINTED COUNTRY	
25. PRINTED TELEPHONE		26. PRINTED FAX		27. PRINTED E-MAIL	
28. PRINTED DATE		29. PRINTED TIME		30. PRINTED SIGNATURE	
31. PRINTED PRINTED NAME		32. PRINTED PRINTED GRADE		33. PRINTED PRINTED TITLE	
34. PRINTED PRINTED ORGANIZATION		35. PRINTED PRINTED ADDRESS		36. PRINTED PRINTED CITY	
37. PRINTED PRINTED STATE		38. PRINTED PRINTED ZIP CODE		39. PRINTED PRINTED COUNTRY	
40. PRINTED PRINTED TELEPHONE		41. PRINTED PRINTED FAX		42. PRINTED PRINTED E-MAIL	
43. PRINTED PRINTED DATE		44. PRINTED PRINTED TIME		45. PRINTED PRINTED SIGNATURE	
46. PRINTED PRINTED PRINTED NAME		47. PRINTED PRINTED PRINTED GRADE		48. PRINTED PRINTED PRINTED TITLE	
49. PRINTED PRINTED PRINTED ORGANIZATION		50. PRINTED PRINTED PRINTED ADDRESS		51. PRINTED PRINTED PRINTED CITY	
52. PRINTED PRINTED PRINTED STATE		53. PRINTED PRINTED PRINTED ZIP CODE		54. PRINTED PRINTED PRINTED COUNTRY	
55. PRINTED PRINTED PRINTED TELEPHONE		56. PRINTED PRINTED PRINTED FAX		57. PRINTED PRINTED PRINTED E-MAIL	
58. PRINTED PRINTED PRINTED DATE		59. PRINTED PRINTED PRINTED TIME		60. PRINTED PRINTED PRINTED SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02486

CERTIFICATE OF DEATH

02444

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 15-1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				d. STREET ADDRESS <u>935 BODIFANT</u>			
3. NAME OF DECEASED (Type or print) First <u>VIVIAN</u> Middle <u>MORRISON</u> Last <u>DUNCAN</u>				4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>CAU.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jun 30 1898</u>	
				9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William B. Morrison</u>			
14. MOTHER'S MAIDEN NAME <u>Ella E. Hume</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>578-32-1478</u>				17. INFORMANT <u>Mrs. Henry H. Tetrault</u> <u>10278 Meedith Ave. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute renal failure, cause unknown</u> <u>593X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/14</u> , 1966, to <u>2/19</u> , 1966, that (I) (we) last saw the deceased alive on <u>2/19</u> , 1966, and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Pollen</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN MD</u>				22d. ADDRESS <u>10511 SUMMIT AVE KENNESAW, GA</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 23, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington, Va.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02487

CERTIFICATE OF DEATH

Items 8 & 9, Film G-374 3/7/66 cac

02445

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg	
c. LENGTH OF STAY IN 1b 61 yrs		d. STREET ADDRESS 10 Oak Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Merton Middle Fairall Last Duwall		4. DATE OF DEATH Month Feb Day 21st Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1905 May 26th 1904
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 6 Days 60	11. IF UNDER 24 HRS. Hours 15 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY III	
11. BIRTHPLACE (County & State, or foreign country) Gaithersburg. Montg. Co.		12. CITIZEN OF WHAT COUNTRY? Md. U.S.A.	
13. FATHER'S NAME Calvin Scott Duwall		14. MOTHER'S MAIDEN NAME Sarah L. Fairall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 15-19-24-66	
17. INFORMANT Pearl W. Duwall. Gaithersburg. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery sclerosis DUE TO (c) Myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 wk ?			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-19-1966 to 2-21-1966 that (I) (we) last saw the deceased alive on 2-19-1966 , and that death occurred at 9:40 M. from the causes and on the date stated above.			
22a. SIGNATURE F. J. Broschart		22b. DATE SIGNED 2-22-66	
22c. PHYSICIAN'S NAME (Type) F. J. Broschart		22d. ADDRESS Gaithersburg Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-24-66	23c. NAME OF CEMETERY OR CREMATORY Forest Oak	23d. LOCATION (City, town or county) (State) Gaithersburg. Md.
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.		25a. REC'D BY REGISTRAR FEB 25 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02488						02446					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Montgomery			Takoma Park			Maryland			Prince Georges		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			e. IS RESIDENCE ON A FARM?		
12 hrs 35 min			Washington Sanitarium + Hospital			Hyattsville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH		5. AGE (In years last birthday)			
ERNEST EUGENE EMERSON						2 - 27		87 yrs.			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
Male		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6-6-78		87 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
						Maryland				USA.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Ernest Emerson						Georanna Grimes					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
none						Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										2 days	
IMMEDIATE CAUSE (a) Pneumonia, Bilateral Fulminating											
493 X OUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) OUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?	
Congestive Heart Failure - Atherosclerosis										YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED	
Hour a.m. p.m. 19										While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2 - 1955, to 2-26, 1966, that (I) (we) last saw the deceased alive on 2-26 1966, and that death occurred at 5 AM, from the causes and on the date stated above.											
22a. SIGNATURE										22b. DATE SIGNED	
Robert B. Tracy										2-27-66	
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS	
Robert B. Tracy										7105 Riggs Rd Hyattsville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF	
Burial										March 2, 1966	
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City, town or county) (State)	
Rock Creek Cemetery										Washington D. C.	
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR	
F. Gaschons Hyattsville, Md										MAR 3 1966	
25b. REGISTRAR'S SIGNATURE											
J. Charles Judge											

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Montgomery
James
Washington
August 27
1944

Chief Clerk
James
Washington
August 27
1944

James
Washington
August 27
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02489

Item #1d Film #0373 2/15/66

02448

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5602 Madison St.</u>				d. STREET ADDRESS <u>5602 Madison Street</u>			
3. NAME OF DECEASED (Type or print) <u>ALICE M. EVANS</u>				4. DATE OF DEATH <u>Feb 2 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov-19-1874</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert Highley</u>				14. MOTHER'S MAIDEN NAME <u>Anne Westover</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>- - -</u>				16. SOCIAL SECURITY NO. <u>218-54-5329</u>			
17. INFORMANT <u>Helen Evans</u>				Address <u>Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular</u> DUE TO (c) <u>Atherosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senile Emphysema</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1959</u> , to <u>Feb 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 1 1966</u> , and that death occurred at <u>8:22</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>James E. Nolan</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb 3-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>James E. Nolan</u>				22d. ADDRESS <u>Washington Clinic, Western Ave.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>2-5-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Farmington, Mo.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>FEB 89 1966</u>			
5130 Wisc. Ave. N.W. Wash. D.C.				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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THE STATE OF TEXAS

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02490

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02449

1. PLACE OF DEATH a. COUNTY Mont. CO.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b D.C.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Market	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles McClelland Evans		4. DATE OF DEATH Month Feb. Day 11 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/03	9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR Months IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Charles R. Evans		14. MOTHER'S MAIDEN NAME Vella Woodring		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1920		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Charles Evans Address Same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Cervical Spine & chord compression DUE TO (b) Auto. Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Auto. Accident				INTERVAL BETWEEN DEATH AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Intarction				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collision with Auto. Head on - when drove his car over yellow			
20c. TIME OF INJURY Month, Day, Year 3:25 p.m. Feb 11 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Highway 128	
		20f. (City or town) (County) (State) R. Damascus Mont. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) John G. Ball		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		2/12/66	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-15-66		23c. NAME OF CEMETERY OR CREMATORY Liberty Baptist	
		23d. LOCATION (City or Town) (County) (State) Lisbon Md.			
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR FEB 16 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02451

02491

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (rural)			c. LENGTH OF STAY in 1b 32 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 2511 Palmer Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Patrick Middle Francis Last FAGAN				4. DATE OF DEATH Month February Day 20 Year 19 66			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 August 1885	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. BIRTHPLACE (County & State, or foreign country) South Boston, Mass		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Navy				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (County & State, or foreign country) South Boston, Mass	
13. FATHER'S NAME Thomas Fagan				14. MOTHER'S MAIDEN NAME Mary Conroy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 579 60 6171		17. INFORMANT Edith Leonard Washington, D. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatoma 1550 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Jan. 19 , 19 66 , to Feb. 20 , 19 66 that (X) (we) last saw the deceased alive on Feb. 20 , 19 66 , and that death occurred at 420A M, from causes and on the date stated above.							
22a. SIGNATURE V. N. Polglase				22b. DATE SIGNED 21 Feb 1966		22c. PHYSICIAN'S NAME (Type) V. N. Polglase LCDR MC USN	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Feb 24-1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City or Town) (County) (State) Arlington, Virginia				24. FUNERAL DIRECTOR Simmons Bros.		25. REC'D BY REGISTRAR FEB 23 1966	
25a. REC'D BY REGISTRAR FEB 23 1966				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1230

2156

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02492											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>1431121212</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GREENBELT</u> d. STREET ADDRESS <u>2 G NORTHWAY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>WALTER</u> Last <u>FARMER</u>						4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/26/14</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Super-Hecht Co</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hecht Co</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Edward Farmer</u>						14. MOTHER'S MAIDEN NAME <u>Florence Bussey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>578-10-4136</u>		17. INFORMANT <u>Elsie O. Farmer</u> Address <u>2-G Northway Greenbelt, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral metastasis</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Bronchogenic carcinoma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 2, 1966</u> to <u>Feb 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 2, 1966</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Henry Wolfe</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2/2/66</u> 22c. PHYSICIAN'S NAME (Type) <u>Henry Wolfe, M.D.</u> 22d. ADDRESS <u>905 Sheridan St., Hyattsville, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-5-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>		
24. FUNERAL DIRECTOR <u>Thomas C. Humphrey</u> ADDRESS <u>8434 Georgia S.E.D.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
DATE <u>FEB 7 1966</u>											

02452

02452

Montgomery
Silver Spring
Holy Cross Hospital
Norman
Mr. Farmer
White
Stark State Bank & Trust Co.

Cardinal
Bronchogenic carcinoma

Henry White, M.D.
905 Sheridan St., Hyattsville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02493

CERTIFICATE OF DEATH

02453

PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		d. STREET ADDRESS <u>R # 2 Box 92</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Albert Garland Fink</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>14</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 24, 1888</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Rockingham Co, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Fink</u>				14. MOTHER'S MAIDEN NAME <u>Martha Cullers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>son - Elmer Fink</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , 19 <u>62</u> , to <u>Feb 13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 11</u> , 19 <u>66</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Luciano I. Leal</u>				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>Luciano I. Leal</u>				22d. ADDRESS _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-16-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Lutheran</u>		23d. LOCATION (City, town or county) (State) <u>Redland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 15 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

02423

02423

Albert Garland Pink

Custodian

Unknown

2-16-42
St. Luke's Lutheran
Bedland, Md.
Francis H. Barber
Daytonville, Md.

Cleared medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

02494

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02455

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>2 1/2 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1209 NORTH BELGRADE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES F. HITTERY</u> First Middle Last 4. DATE OF DEATH <u>2</u> <u>6</u> <u>1966</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>5/29/89</u> 9. AGE (in years last birthday) <u>16</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from Bethlehem Steel Co.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u> 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>UNKNOWN</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> 17. INFORMANT <u>BETTE VUCCI</u> Address <u>1204 BELGRADE SILVER SPRING, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral metastasis</u> DUE TO (c) <u>carcinoma of the lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>3 mo's</u> <u>6 mo's</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 6</u> , 19 <u>66</u> , to <u>Feb 6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 6</u> , 19 <u>66</u> , and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold W. Draper</u> 22c. PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER</u> 22b. DATE SIGNED <u>Feb 6, 1966</u> 22d. ADDRESS <u>10620 Georgia Ave, Silver Spring, MD</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2-8-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>EBENEZER</u> 23d. LOCATION (City, town or county) (State) <u>LEBANON, PA.</u>			
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS</u> ADDRESS <u>8655 4th AVE</u> 25a. REC'D BY REGISTRAR <u>FEB 9 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

02130

02130

CHURCH OF THE
SACRAMENT
1000 1st St
San Francisco, Cal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02495

02456

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1015 DeBeck Drive			d. STREET ADDRESS 2 Cedar Court		
3. NAME OF DECEASED (Type or print) First Middle Last Hazel V. Floyd			4. DATE OF DEATH Month Day Year Feb. 19, 1966		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/1886	9. AGE (In years last birthday) IF FUNERAL 1 YEAR IF UNDER 24 HRS. 79 yrs. Months Days Hours Min. Nov 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Kentucky	
13. FATHER'S NAME Flynn			14. MOTHER'S MAIDEN NAME White		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 403-28-3909-A		17. INFORMANT Address (Daughter) Mrs. George Parrish -same address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> 5711 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastroenteritis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 12 hours 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 14, 1966</u> , to <u>Feb 19, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 19, 1966</u> , and that death occurred at <u>12:00</u> P.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>Stephen C. Cromwell</u>			22b. DATE SIGNED 2-20-66		
22c. PHYSICIAN'S NAME (Type) Stephen Cromwell			22d. ADDRESS 615 W. Montgomery Ave., Rockville, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Transit		23b. DATE THEREOF 2/20/66		23c. NAME OF CEMETERY OR CREMATORY Louisville, Kentucky	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Md.			25a. REC'D BY REGISTRAR FEB 23 1966		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

03158

03158

Green Leaflet Annual Home Booklet, 1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

02496

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02457

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>38 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				e. STREET ADDRESS <u>14000 Columbia Pike</u>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>NIXON</u> Last <u>FLOYD</u>				4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/94</u>	9. AGE (in years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICE DEPT. & TEL. CO.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>(RETIRED)</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Richard Floyd</u>				14. MOTHER'S MAIDEN NAME <u>Ida Carruthers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>577-30-5067</u>		17. INFORMANT Address <u>Margaret S. Floyd same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure, acute</u> DUE TO (b) <u>Hypertensive - arteriosclerotic</u> DUE TO (c) <u>Cardiovascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intestinal Obstruction (Jejunum)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1966</u> to <u>Feb 9, 1966</u> , that (I) was last saw the deceased alive on <u>Feb 9, 1966</u> , and that death occurred at <u>8 PM</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Bernard A Fitzgerald</u>				22b. DATE SIGNED <u>2-9-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A FITZGERALD</u>				22d. ADDRESS <u>217 University Blvd E Ad Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>2/12/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md</u>	
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>		ADDRESS <u>2901 14th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2850

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02497

CERTIFICATE OF DEATH

02458

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>26 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>1502 Jefferson St</u>		9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur Hartman Ford</u>				4. DATE OF DEATH <u>Feb. 12 1966</u>		Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-16-03</u> 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Ford</u>				14. MOTHER'S MARDEN NAME <u>Martha Forman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-44-7223</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, infection</u> 4201 DUE TO <u>Illness of second attack</u> 12/13/64/11 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO <u>second attack was sudden & death</u> (b) <u>immediately</u> (c) <u>immediately</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> 1 day hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/26/66</u> , 19 <u>66</u> , to <u>2/12/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Chas H Wolohon, M.D.</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolohon, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/16/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Cothman Manor, Md</u>	
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		ADDRESS <u>Mt. Rainier Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

80130

80130

NO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02498 CERTIFICATE OF DEATH 02459									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>8 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Hall Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>D.C. 47-3</u> d. STREET ADDRESS <u>1155-11th Ave. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>EDITH</u> Middle <u>V.</u> Last <u>FORD</u>			4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>3</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-7-75</u>		9. AGE (In years last birthday) <u>90</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Daniel Simonds</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Marks</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Carl E. Browning</u> Address <u>17 Parkway Road Hgt. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 4201 DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>									INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>DEC. 19, 1965</u> to <u>FEB. 3, 1966</u> , that (I) (we) last saw the deceased alive on <u>FEB. 3, 1966</u> , and that death occurred at <u>9:15 M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Henry J. Lowder</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>2/3/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>LOWDER</u>					22d. ADDRESS <u>5206 Norway Dr. Chevy Chase, Md.</u>				
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-8-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>			
24. FUNERAL DIRECTOR <u>W.W. Chambers & Son</u> ADDRESS <u>517-11th St. N.E.</u>					25a. REC'D BY REGISTRAR <u>FEB 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

03450

03450

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02499					02460						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY <u>MONTGOMERY</u> MARYLAND					a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>46 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Maryland 15-1</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>					d. STREET ADDRESS <u>8124 Hamilton Spring Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GRACE F. FULLER</u>					4. DATE OF DEATH <u>FEB. 16 19 66</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-2-02</u>		9. AGE (In years last birthday) <u>63 yrs.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MANUFACTURING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>BERNARD FARRELL</u>					14. MOTHER'S MAIDEN NAME <u>ANNIE SULLIVAN</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>CHARLES E. GREENE-8124 HAMILTON SPRING RD.</u>		Address <u>BETHESDA MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>174X Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Adenocarcinoma of uterus</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>9 mo.</u> <u>1 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>65</u> , to <u>Feb 16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 15</u> , 19 <u>66</u> , and that death occurred at <u>8:25 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>John Lawrence Avery</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>2/16/1966</u>						
22c. PHYSICIAN'S NAME (Type) <u>JOHN LAWRENCE AVERY</u>					22d. ADDRESS <u>10110 Georgia Ave., Silver Spring Md</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. BENEDICT Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Boston, Mass.</u>					
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, Inc., Silver Spring, MD</u> ADDRESS					25a. REC'D BY REGISTRAR <u>FEB 23 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

CCAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>29</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sen & Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u> d. STREET ADDRESS <u>5614 Chillum Rd. Apt. 101</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Antonia Mariana Fuste</u> First Middle Last			4. DATE OF DEATH <u>2-10-1966</u> Month Day Year			5. SEX <u>Male</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>9-12-87</u>			9. AGE (In years last birthday) <u>78</u> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>						11b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Cuba</u>		
12. CITIZEN OF WHAT COUNTRY? <u>Cuba</u>						13. FATHER'S NAME <u>Pedro Pedro Fuste</u>					
14. MOTHER'S MAIDEN NAME <u>Marie Vil</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NONE</u>					
16. SOCIAL SECURITY NO.						17. INFORMANT Address <u>Hospital Records</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>2923</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYELOPROLIFERATIVE DISEASE (MYELOFIBROSIS)</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>SEV. years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/13</u> , 19 <u>66</u> , to <u>2/10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> , 19 <u>66</u> , and that death occurred at <u>6:35</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard H. Pollen</u>						22b. DATE SIGNED <u>2/11/66</u>			22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>		
22d. ADDRESS <u>10511 SUMMIT AVE, KENSINGTON, Md</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Feb 12, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town or county) (State) <u>Wheaton Md.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>F. Gasch & Sons Hyattsville, Md.</u>						25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

00250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
02501 1. PLACE OF DEATH a. COUNTY <u>Montgomery,</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Yorktown Village</u> c. LENGTH OF STAY IN 1b <u>30 years +</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5215 Mass. Ave.,</u>						02462 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Yorktown Village, Md. (Washington)</u> d. STREET ADDRESS <u>5215 Mass. Ave.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Josephine</u> First Middle Last 4. DATE OF DEATH <u>Feb</u> Month <u>13</u> Day <u>19</u> Year <u>66</u>			5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 11, 1893</u> 9. AGE (in years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Social Worker</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Charles B. Chapman</u> 14. MOTHER'S MAIDEN NAME <u>Frances Chatterton</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>?</u> 17. INFORMANT <u>John C. Gager, (same as Item 1.) Son.</u> Address			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> DUE TO (b) <u>Hypertensive heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>with cardiomegaly</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> , to <u>Feb 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 9, 1966</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.								
22a. SIGNATURE <u>C P Ryland</u> 22b. DATE SIGNED <u>2-13-66</u> 22c. PHYSICIAN'S NAME (Type) <u>C P RYLAND</u> 22d. ADDRESS <u>4400-49 St NW Wash DC 20016</u>			23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Feb. 16, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington, Natl.,</u> 23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia.</u>								
24. FUNERAL DIRECTOR <u>H. Dow. DeVol</u> ADDRESS <u>Wash. D.C.</u> 25a. REC'D BY REGISTRAR <u>FEB 16 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>											

15485

15485

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02502					02463				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			a. STATE <u>MARYLAND</u>		b. COUNTY <u>Prince George's</u>		
		c. LENGTH OF STAY IN <u>2 mo 27 da</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills</u>		d. STREET ADDRESS <u>5130 Fisher Rd</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <u>Samuel</u> Middle <u>L.</u> Last <u>Gardiner</u>			DATE OF DEATH		Month <u>Feb.</u> Day <u>15</u> Year <u>1966</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 26 1884</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH Navy</u>		11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Samuel L. Gardiner</u>			14. MOTHER'S MAIDEN NAME <u>unk</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Geo E. Gardiner 6013-27 Ave SE</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 4200 DUE TO (b) <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)									INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>concomitant of prostate</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 21, 1965</u> to <u>Feb 15, 1966</u> that (I) (we) last saw the deceased alive on <u>Feb 15, 1966</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/15/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>H F Kreuzburg</u>					22d. ADDRESS <u>7852 16th St NW Wash DC</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 18-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland.</u>			
24. FUNERAL DIRECTOR <u>Simmons Bros</u> ADDRESS <u>1661- Gd. Hope Rd. SE. Wash.DC.</u>					25a. REC'D BY REGISTRAR <u>FEB 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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05203

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "A-1" and "B-1" are faintly visible.]

[Handwritten signature or initials.]

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

02503

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02464

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 15-1	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 8 Cedar Court	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle Cornelius Last Gentry		4. DATE OF DEATH Month February Day 5 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/17
9. AGE (In years last birthday) yrs. 48		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver		10b. KIND OF BUSINESS OR INDUSTRY Transportation	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Gentry		14. MOTHER'S MAIDEN NAME Unavailable	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. II		16. SOCIAL SECURITY NO. 241-07-6581	
17. INFORMANT Wife, Beulah Gentry		Address Same address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO (b) Coronary artery heart disease. DUE TO (c) Coronary artery heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED Febr. 6, 1966	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		Address (Street, city, town, or county) Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 9, 1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Tyson Wheeler		25a. REC'D BY REGISTRAR FEB 8 1966	
ADDRESS 1331 Rockville Pike Rockville, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02504

02465

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>2200 Parker Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLYDE (NMN) GEORGE</u>				4. DATE OF DEATH Month Day Year <u>Febr. 1, 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-22-1914</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. GOV'T.</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Ira George</u>				14. MOTHER'S MAIDEN NAME <u>Lillie Kirby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>579-18-8494</u>		17. INFORMANT Address <u>Mrs. Helen George (Wife)</u> SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Artery Heart Disease</u> (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. DATE SIGNED <u>Feb. 1, 1966</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u> Address (Street, city, town, or county) <u>Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-3-66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Avenue</u> <u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>Feb 7 1966</u> 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02505											
02466											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TRKONA PK.</u> c. LENGTH OF STAY IN 1b <u>36 hrs 45 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SAN & HOSP</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>P. G.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>R DELPHI</u> d. STREET ADDRESS <u>1814 METZGEROTT</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MARGARET ELIZABETH GERARD</u> First Middle Last 4. DATE OF DEATH <u>2</u> <u>14</u> <u>19</u> <u>66</u> Month Day Year						5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-20-03</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H/S WIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>DC</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>JOHN H RHODES</u> 14. MOTHER'S MAIDEN NAME <u>Jeanece Headley</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Rob. Chant</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>12 HOURS</u> 3 YEARS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS SEVERE 15 YEARS</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>63</u> , to <u>2/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> 19 <u>66</u> , and that death occurred at <u>2:45</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Hugh W Irey</u> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>HUGH W IREY</u> 22d. ADDRESS <u>7105 - RIGGS RD, HYATTSVILLE, MD</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-17-1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> 23d. LOCATION (City, town or county) (State) <u>Silver Spring Md</u>											
24. FUNERAL DIRECTOR <u>Wattingly Funeral Home Washington, DC</u> 25a. REC'D BY REGISTRAR <u>FEB 16 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

02502

02502

MARGARET CLIFFORD
 F. W. [illegible]
 H. [illegible]
 J. H. [illegible]
 [illegible]

MYOCARDIAL INFARCTION
 AFTER [illegible] HEART DISEASE
 DIABETES MELLITUS
 [illegible]

HUGH W. IRBY
 [illegible]
 [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02506 Item #2b,c & d #11-#1372 2/1/66											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>NEW JERSEY</u> b. COUNTY <u>Essex</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>10-2-65-2-7-66</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LINCOLN, Baltimore</u>				d. STREET ADDRESS <u>12121 Remington Dr., S.S. Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home - Wheaton, Md.</u>											
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>Mae</u> Last <u>GLOVER</u>						4. DATE OF DEATH Month <u>FEB</u> Day <u>7</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-19-73</u>		9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress Maker Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Fishers Eddy, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANN, John</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Sparks</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Howard Rohr</u> Address <u>12121 Remington Drive Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonism</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from <u>10-3, 1965</u> , to <u>2-7, 1966</u> , that (we) last saw the deceased alive on <u>2-7 1965</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>D. J. Sengstack M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-7-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. J. Sengstack, M. D.</u>						22d. ADDRESS <u>9241 Columbia Blvd., Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-9-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East Ridge Lawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Delawanna, New Jersey</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03200
18107
Montgomery, Hector

Red information filled in missing home.

Red information by missing home
J.C.

Female W
X
7-10-73
A.2.U. New York, N.Y.
M.2.A.
M.2.A.
Down John

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

M

02507

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02468

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 15-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>604 Monroe St Apt</u>			
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>Paul</u> Last <u>Gooding Jr</u>				4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 18, 66</u>	9. AGE (In years last birthday) yrs. <u>25</u>	IF UNDER 1 YEAR Months <u>25</u> Days <u>32</u>		IF UNDER 24 HRS. Hours <u>32</u> Min. <u>32</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dennis Paul Gooding</u>				14. MOTHER'S MAIDEN NAME <u>Beborah Ann Stromberg</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural and subarachnoid hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>760.0</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tentorial tear with hemorrhage</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-18</u> , 19 <u>66</u> , to <u>2-19</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>2-19</u> , 19 <u>66</u> , and that death occurred at <u>3:50</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip H. Varner</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Philip H. Varner</u>	
22d. ADDRESS <u>10620 Rd, Ave., Wheaton, Md.</u>		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/26/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u>				DATE <u>MAR 3 1966</u>			

6-213720

12504

12507

Subtotal and miscellaneous hemorrhage

Tonsillar tons with hemorrhage

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02508

02469

1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring, Md. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) United Church of Christ Home, Inc., 8505 Springdale Rd., Silver Spring, Md.				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring, d. STREET ADDRESS 8708 Colesville Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) May		First Shaul		Middle Grantham		Last February 2 19 66	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH Oct. 18, 1889	
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months 76		IF UNDER 24 HRS. Days 76		Hours 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired personnel clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) Middleway, W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George B. Shaul				14. MOTHER'S MAIDEN NAME Katherine Murphy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John Shaul Address 121 Woodhall Road Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to 2 Feb 1966 , that (I) (we) last saw the deceased alive on 2 Feb 1966 , and that death occurred at 1 P.M. from the causes and on the date stated above.							
22a. SIGNATURE William D. And				22b. DATE SIGNED 2-3-66		22c. PHYSICIAN'S NAME (Type) William D. And	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-5-66		23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery		23d. LOCATION (City, town or county) (State) Middleway, W. Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.				25. REGISTRAR'S SIGNATURE FRANCIS J. JONES		25b. REGISTRAR'S SIGNATURE FRANCIS J. JONES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

03489

03489

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02509					02470						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Montgomery					a. STATE Florida						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					b. COUNTY Ormond Beach						
c. LENGTH OF STAY IN 1b 149 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11 Seaside Drive						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center					d. STREET ADDRESS 11 Seaside Drive						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First			Middle			Last		
			Maria			Erhardina			Greaves		
4. DATE OF DEATH			Month			Day			Year		
			February			7			19 66		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		September 18, 1892		73 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Housewife				None				Sweden			
12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Klaus Rosengrin						14. MOTHER'S MAIDEN NAME Maria Ringquist					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. None					
17. INFORMANT The Medical Record						Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia (Clinical)											
6926 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Lower abdominal abscess											
DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
Hemolytic Anemia years											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
Hour a.m. p.m.				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20f. (City or town) (County) (State)			
19											
21. I certify that XX (this hospital) attended the deceased from September 11, 1965 , to February 7, 1966 , that XX (we) last saw the deceased alive on February 7, 1966 , and that death occurred at 4:15 PM , from the causes and on the date stated above.											
22a. SIGNATURE Bert W. O'Malley											
22b. DATE SIGNED 7 February 1966											
22c. PHYSICIAN'S NAME (Type) Bert W. O'Malley, M.D.											
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
BURIAL			2/10/1966			FAIRVIEW CEMETERY			WEST HARTFORD, CONNECTICUT		
24. FUNERAL DIRECTOR Gerry S. Hysong						25a. REC'D BY REGISTRAR FEB 10 1966					
ADDRESS HYSOY'S FUNERAL HOME 1300 N. ST., N.W. WASH. D.C.						25b. REGISTRAR'S SIGNATURE Charles Judge					

05470

05509

Montgomery
The Clinical Center
1000 Peach Drive
Nashville, Tennessee 37203
Telephone: (615) 255-1234
Fax: (615) 255-1235
E-mail: info@clinicalcenter.com
Website: www.clinicalcenter.com
The Clinical Center is a leading provider of medical services and research. We are committed to providing the highest quality care to our patients and to advancing the frontiers of medical knowledge through our research programs. Our facilities are state-of-the-art and our staff is highly trained and experienced. We welcome inquiries from patients, physicians, and researchers alike.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02510					02471				
1. PLACE OF DEATH a. COUNTY MONTGOMERY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKEVILLE				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARVEY JOHN GREEN			4. DATE OF DEATH Month Day Year FEBRUARY 12 19 66						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/24/85	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer and carpenter			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer and carpenter			10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOHN GREEN				14. MOTHER'S MAIDEN NAME REBECCA WEBER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 217-32-1325		17. INFORMANT Hospital Records		Address Olney, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2001 Lymphosarcoma, generalized DUE TO (b) Arteriosclerotic cardiovascular disease - 10 years DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 14 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6/1/8 1956 to 7/1/2 1966, that (I) last saw the deceased alive on 7/1/2 1966, and that death occurred at 5:30 PM, from the causes and on the date stated above.									
22a. SIGNATURE James P. Kerr					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/12/66		
22c. PHYSICIAN'S NAME (Type) James P. Kerr					22d. ADDRESS Damascus, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-16-66		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		23d. LOCATION (City, town or county) (State) Sunshine, Md.		
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.					25a. REC'D BY REGISTRAR FEB 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02511

CERTIFICATE OF DEATH

02472

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>167 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mervin</u> Middle <u>Albert</u> Last <u>GROSS</u>		4. DATE OF DEATH Month <u>February</u> Day <u>24</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1916</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Daniel Gross</u>		14. MOTHER'S MAIDEN NAME <u>Emma C. Kraft</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>168-16-3556</u>	
17. INFORMANT <u>Mrs. Edith E. Gross, 223 East LaFrance St./</u>		Address <u>Elmira, N. Y.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Cell Carcinoma with widespread metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (1) (this hospital) attended the deceased from <u>Sept. 10</u> , 19 <u>65</u> , to <u>Feb. 24</u> , 19 <u>66</u> that (1) (we) last saw the deceased alive on <u>Feb. 24</u> , 19 <u>66</u> , and that death occurred at <u>7:15 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>E. J. Frensilli M.D.</u>		22b. DATE SIGNED <u>Feb. 24, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. J. Frensilli M. D.</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/25/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn National Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Elmira, New York</u>
24. FUNERAL DIRECTOR <u>W. W. Chambers Co., 1400 Chapin St., N.W.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 28 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		25c. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02512

CERTIFICATE OF DEATH

Items 13, 14 Film 6374 2/20/66 mh

02473

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 9215 Crosby Road	
3. NAME OF DECEASED (Type or print) First Middle Last ERIC T HAGBERG		4. DATE OF DEATH Month Day Year Feb 20 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDDED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/12/16
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATE DEPARTMENT AND		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary abscess 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral edema DUE TO thrombus (c) Healed myocardial infarction with mural/			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from AUGUST, 1955, to FEB. 20, 1966, that (1) (we) last saw the deceased alive on FEB. 20, 1966, and that death occurred at 9:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James A. Roberts		22b. DATE SIGNED 2/20/66	
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS		22d. ADDRESS 8907 GEO. AVE. SILVER SPRING, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-22-66	
23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR 300 Lee Funeral Home 4th St. N.E. Washington, D.C.		25a. REC'D BY REGISTRAR FEB 24 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

02513

02513



State Department of Washington
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212 Cedar Road
Silver Spring
6 days
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ERIC
Hill Crest Heights
Silver Spring
Washington

Healed myocardial infarction with mural
thrombus
Coronary atherosclerosis
Pulmonary edema

Dr. Thomas H. Brown
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02513

CERTIFICATE OF DEATH

02474

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY in lb 6 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (rural)		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 5300 Ridgefield Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Robert Hair		4. DATE OF DEATH Month February Day 8 Year 19 66	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1881
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New Florence, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Robert Hair		14. MOTHER'S MAIDEN NAME Rose Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes Disch. 11-1-32		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Mrs. Clara Hair		Address 5300 Ridgefield Rd. Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma urinary bladder and acute and chronic polynephritis DUE TO (b) 1810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from Feb. 2 , 19 66 , to Feb. 8 , 19 66 that (I) (we) last saw the deceased alive on Feb. 8 , 19 66 , and that death occurred at 315A M, from causes and on the date stated above.			
22a. SIGNATURE Lawrence G. Jones		22b. DATE SIGNED Feb. 9, 1966	
22c. PHYSICIAN'S NAME (Type) L. A. Jones, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-11-1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Joseph Gawler & Sons,		25a. REC'D BY REGISTRAR FEB 16 1966	
ADDRESS 5130 Wisconsin Ave., N.W. Washington, D. C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

45450

1280

02-00101-1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02514		02475									
1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				47-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>90 Bethesda Silver Spring N.H.</u>						d. STREET ADDRESS <u>4701- Fulton St. N.W.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert B. Hardison</u>			First Middle Last			4. DATE OF DEATH <u>February 2 1966</u>			Month Day Year		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 11, 1972</u>		9. AGE (in years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Judge</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Court</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert DeC. Hardison</u>						14. MOTHER'S MAIDEN NAME <u>Mary Ellen Bibb</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>Mrs. E.C. Gatt (Daughter)</u>				Address <u>Sec Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Infection, Influenza</u> <u>4500</u> DUE TO <u>Arteriosclerosis, General</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8 years</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lower Urinary Tract Obstruction with Calculi</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 18, 1958</u> to <u>Feb 2, 1966</u> that (I) (we) last saw the deceased alive on <u>Febr. 1, 1966</u> and that death occurred at <u>4:29 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Dr. Bacon</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Bacon M.D.</u>						22d. ADDRESS <u>1150 Conn. Ave. N.W. Wash. D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>2-4-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland Md.</u>			
24. FUNERAL DIRECTOR <u>Jos. Gawler & Sons, Inc.</u>						ADDRESS <u>5130 Wisconsin Ave. N.W. Wash. DC</u>		25a. REC'D BY REGISTRAR <u>FEB 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

Orteriosclerosis General
Acute Respiratory Infection 3 days
8 years

Lower Urinary Tract Obstruction

~~Stearns~~
Feb 1, 66
Feb 18, 66
Feb 1966

Judge
Male White
Robert B
Court

Hardison
Feb 11 1972
4701 Fulton St NW
Washington
District of Columbia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
2DM 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																					
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery																
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			d. STREET ADDRESS 4504 Maple Avenue													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda-Silver Spring Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
3. NAME OF DECEASED (Type or print) First MAY Middle V. Last HARRIS					4. DATE OF DEATH Month Feb. Day 25, Year 1966																
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24, 1888		9. AGE (In years last birthday) 77 yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td>9</td> <td>1</td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	9	1		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
9	1																				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Decorator				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S.													
13. FATHER'S NAME Charles Townsend Harris					14. MOTHER'S MAIDEN NAME Caroline Bronski																
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Sister Address Florence E. Harris Same as Item 2.															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of colon with metastasis 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 5 months													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from April, 1956, to Feb. 25, 1966, that (I) (we) last saw the deceased alive on Feb. 23, 1966, and that death occurred at 6:50 A.M. from the causes and on the date stated above.																					
22a. SIGNATURE Robert N. Coale				22b. DATE SIGNED Feb. 25, 1966		22c. PHYSICIAN'S NAME (Type) ROBERT N. COALE															
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-25-66		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town or county) (State) Suitland, Maryland															
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY					25a. REC'D BY REGISTRAR Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge														

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

- Cleared with Dr. Reap - Medical Examiner for MD for 1000

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
02516						CERTIFICATE OF DEATH						02477	
1. PLACE OF DEATH a. COUNTY Montgomery County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 45min d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland d. STREET ADDRESS 912 Laredo Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) William Franklin Hatley			First Middle Last			4. DATE OF DEATH 2 25 19 66			Month Day Year				
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/18/21		9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Communication Technician Dept of Defense						10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (County & State, or foreign country) Salisbury N.C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Arlie W. Hatley						14. MOTHER'S MAIDEN NAME May Hatley / Cleo Mae Robinson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Navy WWLL & Korean						16. SOCIAL SECURITY NO. 579-10-5169		17. INFORMANT Dorothy Hatley wife, same as dec.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Coronary occlusive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anteroselective Cerebrovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 2 MONTHS													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from JULY 1953 to FEB 23, 1966 , that (I) (we) last saw the deceased alive on JAN 28 1966 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.													
22a. SIGNATURE Robert L. Krichmar						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED February 25 / 1966					
22c. PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR						22d. ADDRESS 7733 ANASKA AVENUE NW WASHINGTON D.C. 20012							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-1-66		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery				23d. LOCATION (City, town or county) (State) Arlington, Virginia					
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.						ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR MAR 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02517 02478											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clarksburg - Rural c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg - rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Gertrude E. Hawse						4. DATE OF DEATH Month Feb. Day 13 Year 1966					
5. SEX Fem.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/6/1874		9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Montg. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S. A.			
13. FATHER'S NAME Benjamin Burdette						14. MOTHER'S MAIDEN NAME Charity Watkins					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Albert B. Hawse Boyd Md.				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic - cardiovascular disease 4/22/1 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (not known) attended the deceased from 10/1/66 to 1/13/66 , that (I) (not) last saw the deceased alive on 1966 , and that death occurred 1/13/66 from the causes and on the date stated above.											
22a. SIGNATURE James P. Kerr						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/14/66	
22c. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.						22d. ADDRESS Damascus, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/16/66		23c. NAME OF CEMETERY OR CREMATORY Mt. View Methodist		23d. LOCATION (City, town or county) Purdum		23e. (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton						ADDRESS Barnesville, Md.		25a. REC'D BY REGISTRAR Feb 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02518					CERTIFICATE OF DEATH					02479				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>1 day 14 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			116-2						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>					d. STREET ADDRESS <u>8101 Hammond Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Roland</u> Middle <u>John</u> Last <u>Hedquist</u>			4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1966</u>											
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1899 May 29, 1966</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant - retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Review + Herald Pub. Co.</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>			12. CITIZEN OF WHAT COUNTRY? <u>United States</u>					
13. FATHER'S NAME <u>John Hedquist</u>					14. MOTHER'S MAIDEN NAME <u>Alma</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Hospital Records</u>			Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RT Hemiplegia (Meningeal)</u> 352X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Aur Fibrillation</u> DUE TO (c) <u>left Hemiplegia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2/21/66</u> <u>2/22/66</u> <u>1958</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1966</u> Hour <u></u> a.m. <u></u> p.m. <u></u>			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1/24/66</u> , 19 <u>66</u> , to <u>2/22/66</u> , that (I) (we) last saw the deceased alive on <u>2/22/66</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.														
22a. SIGNATURE <u>Howard T Morse</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>2/23/66</u>						
22c. PHYSICIAN'S NAME (Type) <u>Howard T Morse</u>					22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Feb. 26, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>						
24. FUNERAL DIRECTOR <u>Arthur Walters Washington, D.C.</u>					25a. REC'D BY REGISTRAR <u>FEB 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02520

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02481

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10126 Renfrew Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Lee</u> Last <u>Hill</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-75</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jeweler</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>James Hill</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Lee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Daughter</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure A.S.H.D.</u> 4341 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Renal insufficiency</u> DUE TO (c) <u>Cerebral arteriosclerosis + insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-6</u> , 19 <u>66</u> , to <u>2-9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-8</u> , 19 <u>66</u> , and that death occurred at <u>6:45</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles H. Volleton</u>		22b. DATE SIGNED <u>2/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles H. Volleton</u>		22d. ADDRESS <u>1401 Blair Rd NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 14, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Partholm Highland Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Warwick Rhode Island</u>	
24. FUNERAL DIRECTOR <u>Arthur Waters</u>		25a. RECEIVED BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>254 Carroll Street NW, Washington, D.C. 20012</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>FEB 14 1966</u>			

18520

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02521

02483

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>9417-Lanust Hill Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Constance R. Holmead</u>		4. DATE OF DEATH <u>Feb. 6 1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/22</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John M. King</u>	
14. MOTHER'S MAIDEN NAME <u>Pauline Kinsolving</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>7- -</u>		17. INFORMANT <u>Franklin V. Holmead</u> Address <u>1301 E. 1st Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra cerebral hemorrhage</u> DUE TO (b) <u>Acute myelogenous leukemia</u> DUE TO (c) <u>2 mo</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alcohol</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1119/66</u>	
20f. (City or town) <u>2/6/66</u> (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1/19/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/6/66</u> , 19 <u>66</u> , and that death occurred at <u>11:05 PM</u> , from causes and on the date stated above.	
22a. SIGNATURE <u>Jay R. Shapiro</u>		22b. DATE SIGNED <u>2/6/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jay R. Shapiro</u>		22d. ADDRESS <u>8218 Wisconsin Ave md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-9-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. N.W. Wash.</u>		25a. REC'D BY REGISTRAR <u>FEB 11 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05183

RECEIVED

05251

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY, U. S. DEPARTMENT OF AGRICULTURE, WASHINGTON, D. C.

FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY, U. S. DEPARTMENT OF AGRICULTURE, WASHINGTON, D. C.

RE: [Illegible]

[Illegible text follows]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02522

02484

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) 15-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 9707 Bellevue Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Adam HORN				4. DATE OF DEATH Month Feb. Day 8 Year 19 66			
5. SEX male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 27, 1892	
9. AGE (In years lost birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Air Force - Retired		11. BIRTHPLACE (County & State, or foreign country) Liberty, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Adam Horn				14. MOTHER'S MAIDEN NAME Amelia Kregur			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 579 52 7426		17. INFORMANT Mrs. Marguerite A. Horn, Bethesda, Md., 9707 Bellevue Drive/			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Thrombosis, left middle cerebral artery DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from Jan. 30 , 19 66 , to Feb. 8 , 19 66 , that (he) (we) lost the deceased alive on Feb. 8 , 19 66 , and that death occurred at 1:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE William L. Brannon, Jr.				22b. DATE SIGNED Feb. 9, 1966		22c. PHYSICIAN'S NAME (Type) William L. Brannon, Jr., M.D.	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Mary-							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-14-1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Joseph Gawler & Sons, 5130 Wisconsin Ave., N.W.				25a. REC'D BY REGISTRAR FEB 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS Washington, D. C.							

4350

05235

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02523

CERTIFICATE OF DEATH

02485

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
c. LENGTH OF STAY IN 1b <u>6 days.</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban.</u>		d. STREET ADDRESS <u>9707 BELLEVUE DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>JACQUELINE</u> Middle <u>R</u> Last <u>HORN.</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>15</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 7-1924</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SAN ANTONIO TEXAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>COL. CHARLES ADAM HORN.</u>		14. MOTHER'S MAIDEN NAME <u>MARQUEEITE REARDON.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>291-28-6793</u>	
17. INFORMANT <u>MARQUEEITE HORN (mother)</u>		Address <u>9707 BELLEVUE DRIVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, breast, with widespread metastases.</u> 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat White <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>66</u> , to <u>Feb 15</u> , 19 <u>66</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>Feb 15, 1966</u> , and that death occurred at <u>11 P</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Marvin Wadler</u>			22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>			22d. ADDRESS <u>8218 Wisconsin Av. Beth, Md.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-18-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler & Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
5130 Wisc. Ave. N.W. Wash. DC.		DATE <u>FEB 21 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15258

15258

STATE OF TEXAS

Blank lined document with two binder holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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025224 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Item #16 & 12 Film #G374 2/28/66												02486															
Item 23 Film G373 2/23/66 mh																											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>						b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>to Koma Park</i>						c. LENGTH OF STAY IN 1b <i>5 hrs</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince George</i>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanatorium & Hosp.</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						f. STREET ADDRESS <i>11907 Holly tree Court</i>		g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>16-2</i>													
3. NAME OF DECEASED (Type or print) <i>Hettie Jane HORSMON</i>						4. DATE OF DEATH Month <i>2</i> - Day <i>14</i> Year <i>1966</i>						5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-9-1916</i>		9. AGE (In years last birthday) <i>49 yrs.</i>		IF UNDER 1 YEAR Months <i></i> Days <i></i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>						10b. KIND OF BUSINESS OR INDUSTRY <i>D.C.</i>						11. BIRTHPLACE (County & State, or foreign country) <i>U.S.</i>						12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>									
13. FATHER'S NAME <i>Jerry E. Thomas</i>						14. MOTHER'S MAIDEN NAME <i>Emma Boswell</i>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NONE</i>						16. SOCIAL SECURITY NO. <i>579-28-8686</i>						17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>															
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1562 Hepatic coma</i>																											
Conditions, if any, which gave rise to immediate cause (b) <i>metastatic Ca. of liver</i>																											
(a), stating the underlying cause last. (c) <i>Possible Ca breast (vs Gallbladder)</i>																											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>diabetes mellitus</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour <i></i> e.m. <i></i> p.m. <i></i> <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from <i>FEB 5</i> 1965, to <i>FEB 14</i> 1966, that (I) (we) last saw the deceased alive on <i>FEB 13</i> 1966, and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above.												22b. DATE SIGNED <i>2-14-66</i>															
22a. SIGNATURE <i>John R Spencer</i>						22c. PHYSICIAN'S NAME (Type) <i>John R Spencer</i>						22d. ADDRESS <i>BURTONSVILLE, MD</i>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>2/16/66</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Colmar Manor, Md.</i>															
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis Gasch's & Sons</i>						ADDRESS <i>Hyattsville 4739 Batlo. Ave. Md.</i>						25a. REC'D BY REGISTRAR <i>FEB 17 1966</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item #1d Film #G373 2/11/66											
1. PLACE OF DEATH a. COUNTY Montg MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg,					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg.					
c. LENGTH OF STAY IN TB 51Yrs						d. STREET ADDRESS 420 E. Diamond Ave,					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 420 E. Diamond Ave.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First Roberta Middle Columbia Last Jacobs			4. DATE OF DEATH			Month Feb Day 2nd Year 1966		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8th 1885		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days	
										IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife						10b. KIND OF BUSINESS OR INDUSTRY ##		11. BIRTHPLACE (County & State, or foreign country) Woodfield. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Singleton King						14. MOTHER'S MAIDEN NAME Mary Burdette					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT James W. Jacobs. Gaithersburg. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Feb. 1st 1966 to Feb. 2nd 1966 , that (I) (we) saw the deceased alive on Jan. 30 1966 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Jack Schumacher M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 2-3-66		
22c. PHYSICIAN'S NAME (Type) Jack Schumacher M. D.						22d. ADDRESS Gaithersburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-5-66		23c. NAME OF CEMETERY OR CREMATORY Forest Oak			23d. LOCATION (City, town or county) Gaithersburg Md.			
24 FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.						25a. REC'D BY REGISTRAR FEB 7 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		

05485

05258

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02526

02488

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>	
c. LENGTH OF STAY IN 1b <u>16 hrs.</u>		d. STREET ADDRESS <u>7901-River Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Ellis Johnson</u>		4. DATE OF DEATH Month Day Year <u>Feb. 27 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1898</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>	11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Burridge Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Lucinda Adams</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>577-26-0000</u>		17. INFORMANT Address <u>Tebraska F.E. Johnson</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIAL Hypertension</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 Hours</u> <u>20 Years</u> <u>20 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC Renal FAILURE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>FEB 22</u> , 19 <u>66</u> , to <u>FEB 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>FEB 27</u> , 19 <u>66</u> , and that death occurred at <u>5 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Gordon S. Rasmussen M.D.</u>		22b. DATE SIGNED <u>Feb 28/1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Snowden</u>		22d. ADDRESS <u>310 W. Mt. Airy Rd. Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/3/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville Montg. Md.</u>	
25a. REC'D BY REGISTRAR DATE <u>MAR 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05184

REAR TO FORWARD

05250

05184

THE FOLLOWING INFORMATION IS FOR THE USE OF THE
OFFICE OF THE SECRETARY OF DEFENSE
AND IS NOT TO BE RELEASED TO THE PUBLIC
WITHOUT THE EXPRESS WRITTEN PERMISSION
OF THE SECRETARY OF DEFENSE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02527 CERTIFICATE OF DEATH 02490

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>8104 Carroll Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Harold Randolph Keefer</u>		4. DATE OF DEATH <u>February 10 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 30, 1894</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		9b. AGE (In years last birthday) <u>71</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>Potomac Steele</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>McClellan Keefer</u>		14. MOTHER'S MAIDEN NAME <u>Florence Shirk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>Army WWI</u>		16. SOCIAL SECURITY NO. <u>215-09-8767</u>	
17. INFORMANT <u>Goldie C. Keefer</u>		Address <u>8104 Carroll Lane Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS, MASSIVE.</u> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (1) (this hospital) attended the deceased from <u>Feb. 7, 1966</u> , to <u>Feb 9, 1966</u> , that (1) (we) last saw the deceased alive on <u>Feb 9, 1966</u> , and that death occurred at <u>2:24</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>James R Coleman MD.</u> 22b. DATE SIGNED <u>Feb 10, 1966</u> 22c. PHYSICIAN'S NAME (Type) <u>JAMES R COLEMAN</u> 22d. ADDRESS <u>4241 COLUMBIA BLVD. SILVER SPRING MD.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-14-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u> 24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> 25a. REC'D BY REGISTRAR <u>FEB 14 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			

002200

002253

1

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "information" and "subject" are faintly visible.]

[Faint text at the bottom of the page, including what appears to be a date "1961" and some names or titles.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02528

02491

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5817 Kingswood Road		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5817 Kingswood Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stanley Kenneth Kellogg First Middle Last 4. DATE OF DEATH Feb. 20, 1966 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 23, 1893 9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR Months 4 Days 27 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed (Invalid) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) New York 12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Frank Kellogg 14. MOTHER'S MAIDEN NAME Susan Fisher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Wife Anna M. Kellogg Address Same as Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema & fibrosis		INTERVAL BETWEEN ONSET AND DEATH 1 hour? - 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from April, 1962 to 20 Feb, 1966 , that (I) (we) last saw the deceased alive on Jan 20, 1966 , and that death occurred at 1:45 PM , from the causes and on the date stated above. 22a. SIGNATURE George Sharpe 22c. PHYSICIAN'S NAME (Type) GEORGE SHARPE		22b. DATE SIGNED 2-21-66 M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 10511 Summit Ave., Kensington, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 2-21-66 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY Marion Cemetery 23d. LOCATION (City, town or county) (State) Marion, New York		24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY Bethesda, Maryland 25a. REC'D BY REGISTRAR FEB 24 1966 25b. REGISTRAR'S SIGNATURE J. Charles Judge	

00-15-1

2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02529

CERTIFICATE OF DEATH

02492

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			c. LENGTH OF STAY IN TB <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 15-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>2407 SEMINARY RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>HENNESSY</u> Last <u>KOHN</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>7</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-4-84</u> <u>77</u> yrs.	
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Jersey City, New Jersey</u>	
13. FATHER'S NAME <u>Michael Hennessey</u>				14. MOTHER'S MAIDEN NAME <u>Ellen - Clancy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Husband Marion Kohn</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>66</u> , to <u>2/7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> , 19 <u>66</u> , and that death occurred at <u>3 AM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>Richard H. Pollen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>				22d. ADDRESS <u>10511 SUMMIT AVE, KENSINGTON</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-10-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 10 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>g Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05283

STATE OF TEXAS

05283

IN SENATE, FEBRUARY 11, 1903.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE.

FOR THE YEAR 1902.

ALBUQUERQUE, N. M.

1903.

PRINTED BY THE

GOVERNMENT PRINTING OFFICE.

WASHINGTON, D. C.

1903.

U. S. GOVERNMENT PRINTING OFFICE.

WASHINGTON, D. C.

1903.

U. S. GOVERNMENT PRINTING OFFICE.

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WASHINGTON, D. C.

1903.

U. S. GOVERNMENT PRINTING OFFICE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02530 CERTIFICATE OF DEATH 02494

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington DC			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN b. 5 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitorium + Hospital			d. STREET ADDRESS 5711 9th St. NW			
3. NAME OF DECEASED (Type or print) Ludwig Frederick Krafthofer			4. DATE OF DEATH Feb 2 1966			
5. SEX male			6. COLOR OR RACE white			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 6-6-92			
9. AGE (in years last birthday) 73 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Owner			10b. KIND OF BUSINESS OR INDUSTRY Krafthofer's Market			
11. BIRTHPLACE (County & State, or foreign country) D.C.			12. CITIZEN OF WHAT COUNTRY? Amer			
13. FATHER'S NAME Ludwig			14. MOTHER'S MAIDEN NAME Christine Schneider			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 578-46-8655			
17. INFORMANT med. records			Address W. S. H.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 148X BRONCHO PNEUMONIA, terminal DUE TO CARCINOMA, throat (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARKINSONS DISEASE, LEFT SIDE						INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		(County)		(State)		
21. I certify that (I) (this hospital) attended the deceased from JAN. 10, 1966, to FEB 2, 1966, that (I) (we) last saw the deceased alive on 2-2-1966, and that death occurred at 10:30 PM, from the causes and on the date stated above.						
22a. SIGNATURE S. A. Hillman				22b. DATE SIGNED 2-2-66		
22c. PHYSICIAN'S NAME (Type) SAMUEL A. HILLMAN				22d. ADDRESS 8829 FLOWER AVE SILVER SPRING, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/5/66		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cm		
23d. LOCATION (City, town or county) Prig Georges Co Md.		(State)				
24. FUNERAL DIRECTOR H. F. Hunsfurner		ADDRESS 5732 Georgia		25a. REC'D BY REGISTRAR DATE FEB 7 1966		
25b. REGISTRAR'S SIGNATURE Charles Judge						

0510

0520

101

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>2</div> <div>HEALTH DEPT.</div> </div> </div> <div> <div>Items 18&21 Film G3751 3/31/66 TT</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02531</div> <div>02495</div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>as above</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>						d. STREET ADDRESS <u>2332 Naylor Road, S.E.</u>					
3. NAME OF DECEASED (Type or print) <u>Marjorie</u>						4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-13</u>		9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u> </u>					
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>						12. CITIZEN OF WHAT COUNTRY? <u>Canadian</u>					
13. FATHER'S NAME <u>Thomas Begbie</u>						14. MOTHER'S MAIDEN NAME <u>Mary Stewart</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u> </u>					
17. INFORMANT <u>Clifford R. Ladd</u>						Address <u>Same as Item #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute, right, coronary insufficiency;</u> 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery heart disease</u> DUE TO (c) <u> </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>						20f. (City or town) (County) (State) <u> </u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.						22. DATE SIGNED <u>Febr. 17, 1966</u>					
EXAMINER'S NAME (Type) <u>BELDEN R. READ, M.D.</u>						Address (Street, City, town or county) <u> </u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Feb. 19-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>					
ADDRESS <u>Simmons Bros.-1661-Good Hope Rd SE Wash DC</u>						25b. REGISTRAR'S SIGNATURE <u> </u>					

423

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
02532						CERTIFICATE OF DEATH						02496					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> d. STREET ADDRESS <u>247 ROLLINS AVENUE</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>LOUIS I. LANDAU</u>						4. DATE OF DEATH <u>2/21/66</u>						Day Year					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/1/95</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Post Office Dept.</u>						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>SAMUEL COHEN</u>						14. MOTHER'S MAIDEN NAME <u>LENA LEVINE</u>						Address <u>Bethesda, Md.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>NONE</u>						16. SOCIAL SECURITY NO. <u>NONE</u>						17. INFORMANT <u>MARILYN KUELLER-5967-2 prentice rd.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO (b) (c)												INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 yrs.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema; Recent myocardial infarction (3 wks)</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Oct.</u> , 19 <u>65</u> , to <u>Feb 21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb. 21</u> 19 <u>66</u> , and that death occurred at <u>11:17M</u> , from the causes and on the date stated above.																	
22a. SIGNATURE <u>Sidney J. Cohen</u>						22b. DATE SIGNED <u>Feb. 21, 1966</u>											
22c. PHYSICIAN'S NAME (Type) <u>Sidney J. Cohen</u>						22d. ADDRESS <u>50 W. Edmonston Drive, Rockville, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>						23b. DATE THEREOF <u>2/23/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zedek Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Brooklyn N.Y.</u>							
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>						ADDRESS <u>4217-9th St. NW</u>		25a. REC'D BY REGISTRAR <u>FEB 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

15230

RECEIVED

68233

Central station
Company, Inc. account

Payment enclosed; rent deposit - interest (20%)

Oct 11 1911

to E. Adams & Sons, Brooklyn, N.Y.

John J. Adams
242 Broadway, N.Y.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

Items 18-21 Film G375 7-731466
MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02533

02497

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 29 + Briggs - Chaney Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9509 Woodley Avenue</u> d. STREET ADDRESS <u>Silver Spring</u> 15-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARTHA FELDMAN LANZA</u>				4. DATE OF DEATH <u>Febr. 14</u> 19 <u>66</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 6, 1927</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Technician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Jacksonville, Florida</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John R. Feldman</u>				14. MOTHER'S MAIDEN NAME <u>Benlah Barker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>265-24-9477</u>		17. INFORMANT <u>Francisco M. Lanza</u> Address <u>9509 Woodley Avenue Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute poisoning due to potassium cyanide</u> 9718 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ingestion, apparently self-administered.</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased drank mixture of potassium cyanide in a cola drink.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>3:00</u> p.m. <u>2/14</u> 19 <u>66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				22. DATE SIGNED <u>Febr. 14, 1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-17-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		23d. LOCATION (City, town or county) <u>Arlington, Virginia</u> (State) <u></u>	
24. FUNERAL DIRECTOR <u>C. Alan Carter</u> ADDRESS <u>8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02534

02498

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hale Center</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12608 Eldrid Cr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JUNE O. Laubscher</u> First Middle Last				4. DATE OF DEATH <u>2 4 1966</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/15/32</u> yrs. Months Days Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>George Oberndoerfer</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Lawrence E. Laubscher- Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Breast</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>20 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 85, 19</u> , to <u>2/4, 1966</u> , that (I) (we) last saw the deceased alive on <u>2/3 1966</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.							22b. DATE SIGNED <u>2/4/66</u>
22a. SIGNATURE <u>G. Lennard Gold</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. ADDRESS <u>8641 Colesville Rd., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Com</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Md</u>	
24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons, Washington, D.C.</u>				25a. REC'D BY REGISTRAR <u>FEB 9 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1000

1000

J. Lennard Gold, M.D., 1000
1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>														
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM & Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u> d. STREET ADDRESS <u>8452 PINEY BRANCH COURT</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <u>Winifred</u> First Middle Last <u>LAWRIE</u>			4. DATE OF DEATH <u>February 28</u> 19 <u>66</u>			5. SEX <u>FEMALE</u>			6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>December 23, 1882</u> <u>83</u> yrs.			9. AGE (In years last birthday) <u>83</u> yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Macall</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes give war or dates of service) <u>-</u>			16. SOCIAL SECURITY NO. <u>-</u>		
17. INFORMANT <u>Hospital Record</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4221</u> DUE TO <u>Arteriosclerotic cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>unknown</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Febr 20, 1966</u> , to <u>Febr 28, 1966</u> , that (I) (we) last saw the deceased alive on <u>Febr. 28</u> <u>1966</u> , and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above.														
22a. SIGNATURE <u>Eino Magi</u>						22b. DATE SIGNED <u>2-28-66</u>			22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>			22d. ADDRESS <u>831 University Blvd. E. Silver Spring, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>3-3-1966</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>			23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>					
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>						25a. REC'D BY REGISTRAR <u>MAR 7 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION

00150

00330

Butland, No.

Greenery Hill Cemetery

1900-1901

Johnston, N.H. 1901-1902

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02536

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02500

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>10404 Rockville Pike</u>	
3. NAME OF DECEASED (Type or print) <u>Christopher Scott Lechman</u>		4. DATE OF DEATH <u>Feb-21-1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/22/65</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Lechman</u>		14. MOTHER'S MAIDEN NAME <u>Linda Bachman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Linda Lechman</u>		Address <u>10404 Rockville Pike Rockville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>2/21/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2/22/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Northwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Philadelphia, Pa.</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumfrey</u>		ADDRESS <u>Bethesda, Md.</u>	
25a. REC'D BY REGISTRAR <u>FEB 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

100-100

100-100

100-100



[Faint, illegible handwritten text]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

Cleared with medical examiner - Dr. B. Reg.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02537											
02501											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. LENGTH OF STAY IN 1b <u>18 yrs</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>321 Branch Drive</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u>					
d. STREET ADDRESS <u>321 Branch Drive</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Gerald</u>			First <u>Phillip</u>			Last <u>Leicht</u>			4. DATE OF DEATH <u>February</u> <u>4</u> <u>19</u> <u>66</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 21, 1908</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N. L. R. B.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Medford, Wisconsin</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Herman Leicht</u>						14. MOTHER'S MAIDEN NAME <u>Anna Stein</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT <u>Signe R. Leicht</u> Address <u>321 Branch Drive Silver Spring, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac decompensation</u> <u>4/16 X</u> DUE TO (b) <u>Rheumatic heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Cerebral thrombosis - right</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>Many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis - right</u>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> , 19 <u> </u> , to <u>Feb. 4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 7</u> , 19 <u>65</u> , and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb. 4, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>						22d. ADDRESS <u>9301 Colesville Rd., Silver Spring Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>2-5-66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>			23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Maryland</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>					
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						DATE <u>FEB 7 1966</u>					

10250

02551

STATE OF DEATH

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Date of Birth", "Cause of Death", and "Signature" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02538

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02502

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Resmor Sanitarium & Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia COUNTY ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2122 Massachusetts Ave., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MINNIE Middle H. B. Last LEIGH			4. DATE OF DEATH Month FEBRUARY Day 9 Year 1966		
5. SEX Female			6. COLOR OR RACE Caucasian		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 9/27/1871		
9. AGE (in years last birthday) 94 yrs.			10. IF UNDER 1 YEAR Months 47 Days 3		
11. BIRTHPLACE (County & State, or foreign country) Gretnada County, Miss.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Dr. Warren F. Barksdale			14. MOTHER'S MAIDEN NAME Virginia H. MacLaughlin		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 501 Colorado Bldg. Washington, D. C.		
17. INFORMANT (Attorney) Mr. Andrew T. Altmann			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis (chronic brain syndrome) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) _____		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			20f. (City or town) (County) (State) _____		
21. I certify that (I) (this hospital) attended the deceased from 1947 , 19____, to 2/9/66 , 19____, that (I) was last saw the deceased alive on 2/6/66 19____, and that death occurred at 8:28 M, from the causes and on the date stated above.					
22a. SIGNATURE H D Ecker			22b. DATE SIGNED 2/9/66		
22c. PHYSICIAN'S NAME (Type) HENRY D. ECKER, M.D.			22d. ADDRESS 917 20th St., N.W., Washington, D.C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 2/10/1966		
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION (City, town or county) (State) Suitland, Maryland		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.			25a. REC'D BY REGISTRAR FEB 16 1966		
25b. REGISTRAR'S SIGNATURE Charles Judge					

05209

12338

Director of Columbia

Washington

George Washington Hospital

Large

H. H.

24

2/27/41

Female Generalist

Roberts County, Miss.

Honolulu

Virginia E. Buchanan

Dr. Robert A. Buchanan

Mr. Andrew T. Almann
Washington, D. C.

to

2/27/41

217-2024 No. H.H., January 1941

Dr. R. A. Almann, M.D.

Washington, D.C.

1/20/41

Generalist, George Washington, D.C.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

02539

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02503

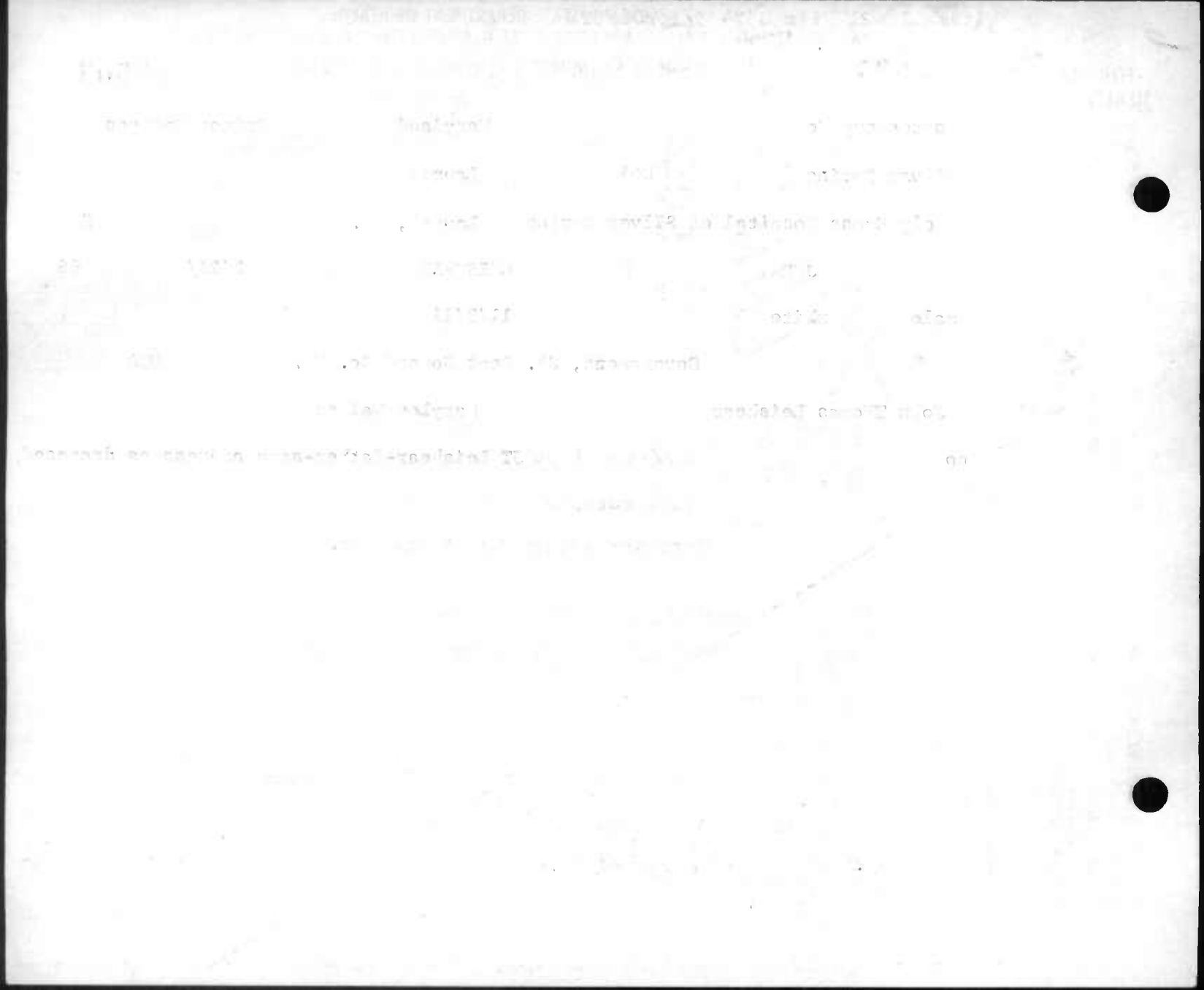
1. PLACE OF DEATH a. COUNTY Montgomery Co MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital of Silver Spring		d. STREET ADDRESS Laurel, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN M LEISHERR		4. DATE OF DEATH Month Day Year 2/25/ 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/11
9. AGE (In years lost birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 16 - 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY Government, St. Dept Howard Co. Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Thomas Leishear		14. MOTHER'S MAIDEN NAME Marylee Walker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-44-967	
17. INFORMANT JT Leishear-father-same address as deceased		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery heart disease. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap, M.D.		22. DATE SIGNED Febr. 25, 1966	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-28-66	23c. NAME OF CEMETERY OR CREMATORY Emmanuel Cem	23d. LOCATION (City or Town) (County) (State) Scaggville Md.
24. FUNERAL DIRECTOR De Witt Donaldson, Laurel Md		25a. REC'D BY REGISTRAR MAR 4 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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Item 21 Film G373 2/11/66 TT											
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02540 CERTIFICATE OF DEATH 02504											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>11 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Milford</u> <u>67-3</u> d. STREET ADDRESS <u>355 Lacey Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Elizabeth (NMN) Levine</u> 4. DATE OF DEATH <u>February</u> <u>4</u> <u>19 66</u>						5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>17 August 1906</u> 9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u> 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>Barnett Prager</u> 14. MOTHER'S MAIDEN NAME <u>Bertha Beiderman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>--</u> 16. SOCIAL SECURITY NO. <u>Not Available</u> 17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissection of left coronary artery while being/</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>canmulated</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>10 Years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Aortic Stenosis 4 Years?</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that <u>it</u> (this hospital) attended the deceased from <u>24 January, 19 66</u> to <u>4 February 19 66</u> , that <u>it</u> (we) last saw the deceased alive on <u>4 February 19 66</u> , and that death occurred at <u>11:00</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Scott Stewart, MD.</u> 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>						22b. DATE SIGNED <u>11:20 AM</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>4 February 1966</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/6/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth Israel Mem. Park</u>				23d. LOCATION (City, town or county) (State) <u>Woodbridge, N. J.</u>	
24. FUNERAL DIRECTOR <u>B. DANZANSKY & SONS 3501 14th St. N. W.</u>						25a. REC'D BY REGISTRAR <u>65B 7 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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Memorandum of the Secretary of the Board of Directors

to the

Board of Directors

Respectfully,

February 1954

I

Very truly yours,

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02541

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02505

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10225 Kensington Pky app 911</u>		d. STREET ADDRESS <u>10225 Kensington Pky 911</u>	
3. NAME OF DECEASED (Type or print) <u>Barbara Burke</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1914</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Computer Programmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Research</u>	
11. BIRTHPLACE (State or foreign country) <u>Neb.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Raymond Burke</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Flinn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>— — —</u>	
17. INFORMANT <u>Lewis Merkt Lind Bethesda, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Inhalation</u> DUE TO (b) <u>Apartment Fire</u> DUE TO (c) <u>Apartment Fire</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell asleep in chair Smoking - Chair & Rug caught Fire -</u>		
20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> a.m. <u>PM</u> <u>2/12</u> 19 <u>66</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>apartment</u>	20f. (City or town) (County) (State) <u>Kensington - Mont. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>2/12/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Prince George, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>2-14-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George, Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>FEB 17 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

50790

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02542											
02506											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
c. LENGTH OF STAY IN 1b <u>26 years</u>						d. STREET ADDRESS <u>8317 Draper Lane</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>XXXXX 8317 Draper Lane</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Dwight Hixson Longley</u>						4. DATE OF DEATH <u>Feb 23 1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 17, 1890</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Consulting Architect</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Kalamazoo, Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hey Longley</u>						14. MOTHER'S MAIDEN NAME <u>Isabelle Mand</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>WWI</u>						16. SOCIAL SECURITY NO. <u>Yes</u>					
17. INFORMANT <u>Saleeta K. Longley</u>						Address <u>8317 Draper Lane Silver Spring, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic heart disease</u> (a), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>6 years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 2</u> , 19 <u>55</u> to <u>Feb 23</u> , 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Feb. 22</u> , 19 <u>66</u> , and that death occurred at <u>2 A.M.</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>John E. Everett</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/23/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>						22d. ADDRESS <u>9400 CONN. AVE. KENSINGTON</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Feb 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>						25a. REC'D BY REGISTRAR <u>FEB 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

SARS

1975: 1980 1985 1990 1995 2000

2.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02543					02507						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY				
MONTGOMERY			BETHESDA		MARYLAND		MARYLAND MONTGOMERY				
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
					GAITHERSBURG 15-1						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS						
Suburban					324 E. DIAMOND AVE						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			F.		ELIZABETH		LOOMIS		FEB 21 19 66		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
FEMALE		White				12/26/11		54 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SEC				Macey's N.Y.				New York		USA.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
William K. Loomis					FRANCES Williams						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT			Address	
							KATHERINE Wells - Sister				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
5411 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)											
peritonitis late											
(c)											
perforated ulcer, cirrhotic liver											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
cirrhosis (advanced) liver 1 yr											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19											
21. I certify that (I) (this hospital) attended the deceased from 2-20-1966, to 2-21-1966 that (I) (we) last saw the deceased alive on 2-21-1966, and that death occurred at 10:45 PM, from the causes and on the date stated above.											
22a. SIGNATURE											
John O. Robben											
22b. DATE SIGNED											
2-21-66											
22c. PHYSICIAN'S NAME (Type)											
JOHN O. ROB BEN M.D.											
22d. ADDRESS											
8007 RUSHING SILVER SPRING MD											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Cremation			2-22-66		Lee's Crematory			Washington, D.C.			
24. FUNERAL DIRECTOR					ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lee Funeral Home					Washington, D.C.			FEB 24 1966		Charles Judge	

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05203



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02544

CERTIFICATE OF DEATH

02508

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>10501 Montrose Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond H. Lucia</u>		4. DATE OF DEATH <u>2-4</u> 19 <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-06</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Audio Engineer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Vermont</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry R. Lucia</u>		14. MOTHER'S MAIDEN NAME <u>Edith Swift</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>104-09-4121</u>	
17. INFORMANT <u>Glenn - Wife - Same as</u>		Address <u>Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Recto sigmoid</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Colon with metastases</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 4</u> , 19 <u>66</u> , to <u>Feb 4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4 Feb</u> 19 <u>66</u> , and that death occurred at <u>1 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>DeWitt E. DeLawter</u>		22b. DATE SIGNED <u>Feb 4, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLawter M.D.</u>		22d. ADDRESS <u>3848 Porter St NW. WASH. DC.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial-transit 2-5-66</u>		<u>White Haven Mem. Park</u>	<u>Pittsburg, New York</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take the carban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

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ROBERT A. TIMOTHY, Secretary, National
Labor Union, 100-90-0131, New York

Cleared with medical Examiner R.B.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
02545 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Law. & Hosp.</u>				02509 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1 d. STREET ADDRESS <u>1023 N. Noyes Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>M</u> Middle <u>LUDWIG</u> Last				4. DATE OF DEATH <u>2</u> Month <u>15</u> Day <u>1966</u> Year							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-19-88</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles. -----</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Knatz</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-----</u>				16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Anna Ballenger (sister)</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> (c)										INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>18 Jan</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>18 Jan</u> , 19 <u>66</u> , and that death occurred at <u>1:35 P.</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Russell B. Arnold</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/15/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b. DATE THEREOF <u>2/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u> ADDRESS <u>Washington, D.C.</u>						25a. REC'D BY REGISTRAR <u>FEB 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Released by Crown

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>11623 LeBaun Terrace</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Nathan</u> Middle <u>Margolis</u> Last <u>Margolis</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1966</u>								
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/19/91</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FURRIER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GARMENT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>MORDECAI MARGOLIS</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>065-18-1512A</u>		17. INFORMANT <u>HAROLD HELSCHEIN</u>			Address <u>(Same as 2 above)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 1810 DUE TO <u>Carcinoma of Bladder</u> (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> 19 <u>66</u> to <u>2/19</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/18</u> 19 <u>66</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Joseph Bloom</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>2/19/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH BLOOM</u>						22d. ADDRESS <u>1015 SPRING STREET SSANMD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/20/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L. MEM. PARK</u>				23d. LOCATION (City, town or county) (State) <u>FALLS CHURCH, VA.</u>			
24. FUNERAL DIRECTOR <u>Holberg Funeral Home</u>						ADDRESS <u>4217-94 St. NW</u>		25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

112511

112511

Received for deposit

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02547

02512

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum Terrace - Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		d. STREET ADDRESS 820 Cox Ave.	
3. NAME OF DECEASED (Type or print) Mary Ellen Marion		4. DATE OF DEATH Feb. 21, 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-04
9. AGE (In years lost birthday) 61 yrs.		IF UNDER 1 YEAR: Months 16 Days 2 IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hswi		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Europe Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Pizzuti		14. MOTHER'S MAIDEN NAME Josephine Sardellitti	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> no <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 577-22-6314	
17. INFORMANT Mike Marion husband		Address same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage due to ruptured DUE TO (b) aneurysm at circle of willis: Essential DUE TO (c) hypertension.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED Febr. 21, 1966	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/24/66	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.
24. FUNERAL DIRECTOR The S. H. Hines Co. Washington, D. C.		25a. REC'D BY REGISTRAR FEB 23 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02548

02513

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>8228 - 14th Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San't Hospital</u>							
3. NAME OF DECEASED (Type or print) <u>Mr. Jack (Marcovitz) Martin</u>		First <u>Middle</u> Last		4. DATE OF DEATH <u>2</u> <u>3</u> <u>1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-14-1890</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Rumania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Martin</u>				14. MOTHER'S MAIDEN NAME <u>Mollie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hyattsville, Md</u> <u>Mrs. Rose Martin 8228 14th Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> (c) <u>known 2 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anemia, History of congestive failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>May 2, 1963</u> to <u>Feb 3, 1966</u> that (1) (we) last saw the deceased alive on <u>Jan 30 1966</u> and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>John R. Spencer</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-3-1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>John R. Spencer, M. D.</u>				22d. ADDRESS <u>BURTONSVILLE 1 M.D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/6/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Washington Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Hyattsville Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>B. DANZANSKY & SONS 3501 14th St. N. W.</u>				25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
Cleared & Dr. Reap for Dr. Sherer to sign certificate
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02549 CERTIFICATE OF DEATH 02514											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San + Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1929 East West Hwy</u> #304 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>WALDEN</u> Middle <u>MARTIN</u> Last 4. DATE OF DEATH <u>2</u> Month <u>5</u> Day <u>1966</u> Year											
5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-22</u>		9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bakery Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Farmington W. Va</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jasper David Martin</u>						14. MOTHER'S MAIDEN NAME <u>Frances Smith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW 2</u>				16. SOCIAL SECURITY NO. <u>236-26-9252</u>		17. INFORMANT <u>Dorothy Carol Martin</u> Address <u>1929 East West Highway Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4222 Congestive Heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Myocardial disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hours</u> <u>3 years</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>6/14</u> , 19 <u>65</u> , to <u>2/5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/5</u> , 19 <u>66</u> , and that death occurred at <u>7A</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Max G. Sherer</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2/5/66</u> 22c. PHYSICIAN'S NAME (Type) <u>MAX G. SHERER MD</u> 22d. ADDRESS <u>800 Pershing Dr. Silver Spring Md</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rural</u>				23b. DATE THEREOF <u>2-8-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>FFB 9</u> DATE <u>1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03843

03844

Present to the Board

W. H. X

11

James C. [illegible]
[illegible]
[illegible]

05210

CERTIFICATE OF DEATH

05250

I hereby certify that on the 12th day of May 1901
 at the residence of the deceased, in the City of New York
 the following named person died:
 Name of Deceased: *William E. Moore*
 Age: *45* years
 Sex: *Male*
 Race: *White*
 Cause of Death: *Heart Disease*
 Signature of Physician: *W. E. Moore*
 Signature of Registrar: *W. E. Moore*
 Date: *May 12, 1901*

I hereby certify that the above is a true and correct copy of the original certificate of death.
 Signature of Registrar: *W. E. Moore*
 Date: *May 12, 1901*
 Signature of Physician: *W. E. Moore*
 Date: *May 12, 1901*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. And in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02551 CERTIFICATE OF DEATH 02516

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 90 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Immaculate Nursing Home 901 Arcola Ave.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Mexico b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Albuquerque 68-3 d. STREET ADDRESS 3006 9th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LeRoy McDowell		First Middle Last		4. DATE OF DEATH 2 11 19 66			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 2/2/93		9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 14 Hours 19 Min.			
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James H. McDowell		14. MOTHER'S MAIDEN NAME Louanna Pusey					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. 579-05-1136		17. INFORMANT Mae McD. Hummer Address Kensington, Md. 4611 Saul Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) stroke DUE TO (c) myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH 3 years 10 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Oct 10, 1964 to Feb 14, 1966 , that (I) (we) last saw the deceased alive on Feb 13, 1966 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE William Brainin M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/14/66			
22c. PHYSICIAN'S NAME (Type) NM BRAININ		22d. ADDRESS 6124 Central Ave, Capital Bldg					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2/16/66		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			
23d. LOCATION (City, town or county) (State) Suitland, Md.							
24. FUNERAL DIRECTOR The S.H. Hines Chapny		25a. REC'D BY REGISTRAR FEB 16 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02552

02517

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS Lot #3- Melwood Mobile Homes	
3. NAME OF DECEASED (Type or print) John Elmer Edward McKenzie		4. DATE OF DEATH Month Feb. Day 27 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/06/40
9. AGE (In years lost birthday) 25 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Francis McKenzie		14. MOTHER'S MARRIAGE NAME Ruth E. Kidwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-38-5287	
17. INFORMANT Ruth Montgomery		Address 2506 - Marlboro	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage with brainstem compression DUE TO (b) due to automobile accident DUE TO (c) 8190 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in truck that struck bridge abutment.	
20c. TIME OF INJURY Month, Day, Year 8:15 p.m. 2/27 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 495		20f. (City or town) (County) (State) Bethesda Mont. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John B. Ball		22. DATE SIGNED 2/28/66	
EXAMINER'S NAME (Type) John B. Ball		M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-66	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION (City or Town) (County) (State) Switzland md	
24. FUNERAL DIRECTOR Lee Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 4 1966	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1017

1017



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>10 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> d. STREET ADDRESS <u>26007 Woodfield Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Bryan</u> Last <u>McSweeney</u>						4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 January 1959</u>		9. AGE (In years last birthday) <u>7</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Bernard E. McSweeney</u>						14. MOTHER'S MAIDEN NAME <u>Frances M. Colebank</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left heart failure with cardiac arrest</u> (b) <u>Constriction of descending aorta</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>					
19. INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>						20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rubella syndrome</u>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>	
21. I certify that (X) (this hospital) attended the deceased from February 7, 1966, to February 17, 1966, that (X) (we) last saw the deceased alive on February 17, 1966, and that death occurred at 11:29 AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Scott Stewart</u>						22b. DATE SIGNED <u>17 February 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Scott Stewart, M.D.</u>			
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
23b. DATE THEREOF <u>Feb. 21, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's</u>		23d. LOCATION (City, town or county) <u>Poplar Springs, Md.</u>		23e. REC'D BY REGISTRAR <u>Feb 21 1966</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>						25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02554

CERTIFICATE OF DEATH

02519

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver SPRING				c. LENGTH OF STAY IN 1b 2 MONTHS 15 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fairland Nursing Home				d. STREET ADDRESS 12804 Matey Rd.			
3. NAME OF DECEASED (Type or print) THOMAS Michael McVerry				4. DATE OF DEATH Month 2 Day 22 Year 1966			
5. SEX M.		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-5-1890	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DETECTIVE SARGEANT D.C. Police		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael McVerry				14. MOTHER'S MAIDEN NAME Emma Desimore Hanorah Carmody			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-48-7913		17. INFORMANT Mrs. Emma Desimore Address 12806 Matey Road Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 1965 , to Feb 22, 1966 , that (II) (we) last saw the deceased alive on Feb 22, 1966 , and that death occurred at 5:25 AM , from the causes and on the date stated above.							
22a. SIGNATURE Michael R. Dobridge				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED FEB 22, 1966	
22c. PHYSICIAN'S NAME (Type) Michael R. Dobridge				22d. ADDRESS 12600 Parkland Dr. Rockville			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 25, 1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR Feb 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

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05254

Feb 22 1946

15 Nov 1945 a letter to the

on 27 Jan 1946 the letter to the
on 27 Jan 1946 the letter to the
on 27 Jan 1946 the letter to the

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02555

02520

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> 15-1	
c. LENGTH OF STAY IN lb <u>4 days</u>		d. STREET ADDRESS <u>9611 W. Bexhill Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>C</u> Middle <u>Wayne</u> Last <u>Mead</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/07</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Architect</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Mead</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Beedy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>YES UNKNOWN</u>	
17. INFORMANT <u>Wife - Virginia - Same</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis of heart</u> DUE TO (c) <u>High blood pressure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 18, 1966</u> to <u>Feb 19, 1966</u> that (I) (we) last saw the deceased alive on <u>Feb 19, 1966</u> and that death occurred at <u>11:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>V.C. de Guzman</u> M.D.		22b. DATE SIGNED <u>Feb 19, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>V. C. de GUZMAN</u>		22d. ADDRESS <u>1150 CONNECTICUT AVE., N.W., WASH. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Type) <u>Cremation</u>	23b. DATE THEREOF <u>2/21/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

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V. C. de GARMAN
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CERTIFICATE OF DEATH

Reg. Dist. No. 02521

02556

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 311 Eldrid Drive		d. STREET ADDRESS 311 Eldrid Drive	
3. NAME OF DECEASED (Type or print) Sadie E. Meiselman		4. DATE OF DEATH Feb. 17, 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1883
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan J. Wickner		14. MOTHER'S MAIDEN NAME Rosa S. Milrad	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 045 16 5279S.	
17. INFORMANT Son		Address Md. S. Harry Meiselman-211 Eldrid Dr., S. S.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis with Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 3 years INTERVAL BETWEEN ONSET AND DEATH 2 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 16, 1966 to Feb 17, 1966 , that I last saw the deceased alive on Feb 16, 1966 , and that death occurred at 12:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sydney Leventhal		ADDRESS (Street, city or town, state) 9210 Coleville Rd.	
PHYSICIAN'S NAME (Type) Sydney Leventhal, M.D.		DATE SIGNED 2/17/66	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/66	
22c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		22d. LOCATION (City, town, or county) (State) Falls Church, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. Dargatzis + Son		ADDRESS 3501 14th St. N.W. Wash. D.C.	
24a. REC'D BY REGISTRAR FEB 21 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1551

DEPARTMENT OF HEALTH BALTIMORE		DATE OF DEATH 1983	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	
PLACE OF SIGNATURE [Illegible]		PLACE OF SIGNATURE [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF WITNESS [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	
PLACE OF SIGNATURE [Illegible]		PLACE OF SIGNATURE [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF DECEASED [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	
PLACE OF SIGNATURE [Illegible]		PLACE OF SIGNATURE [Illegible]	

TO BE FILLED BY THE REGISTRAR

1. NAME OF REGISTRAR

2. ADDRESS OF REGISTRAR

3. PHONE NUMBER OF REGISTRAR

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF REGISTRAR

10. DATE OF SIGNATURE

11. PLACE OF SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02557

02522

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE			
c. LENGTH OF STAY IN lb				d. STREET ADDRESS 1006 GILBERT RD.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Congressional Manor Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frances		First		Middle Mezebish		Last	
4. DATE OF DEATH 2ND		Month		Day 22ND		Year 1966	
5. SEX F		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-25-02	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) Russia	
13. FATHER'S NAME Nathan Goodman				14. MOTHER'S MAIDEN NAME Anna ? UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT SON BURTON MEZEBISH, SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Endometrial Carcinoma 172x DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 yr 4 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 24, 1965 to Feb 22, 1966 that (I) (we) last saw the deceased alive on 2/4, 1966 and that death occurred at 22ND from the causes and on the date stated above.							
22a. SIGNATURE Glenn Maganzini M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A.C. MAGANZINI				22d. ADDRESS 50 W. Edwath Dr. Rockville			
23a. BURIAL, CREMATION, REMOVAL. (Specify) BURIAL		23b. DATE THEREOF 2/24/66		23c. NAME OF CEMETERY OR CREMATORY BETH ISRAEL CEM.		23d. LOCATION (City, town or county) (State) NEW HAVEN CONN.	
24. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home				ADDRESS 4217-94 St. NW		25a. REC'D BY REGISTRAR Feb 25 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

12380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington					c. LENGTH OF STAY IN 1b 15-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4114 Warner Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) RUDY JOHN MIHALICK					4. DATE OF DEATH February 1 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-7-1898		9. AGE (In years last birthday) 67 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer (Retired)					10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) Budapest, Hungary					12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 578-03-4606					
17. INFORMANT Herma Mihalick (Wife)					Address See Item #2.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic Heart Disease DUE TO (c) Generalized arteriosclerosis										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 11 , 19 64 , to Feb 1 , 19 66 , that (I) (we) last saw the deceased alive on Dec 23 , 19 65 , and that death occurred at M , from the causes and on the date stated above.										
22a. SIGNATURE Clara H. Trau					22b. DATE SIGNED Feb 1, 1966					
22c. PHYSICIAN'S NAME (Type) Joseph Gawler					22d. ADDRESS 8237 Georgia Ave - Silver Spring, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2-2-1966			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION (City, town or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.										
25a. REC'D BY REGISTRAR Feb 8 1966										
25b. REGISTRAR'S SIGNATURE J. Charles Judge										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02539

02524

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 64 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY Shanks c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (No street address) d. STREET ADDRESS (No street address) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert Lee Montgomery			4. DATE OF DEATH Month February Day 12 Year 1966				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1954	9. AGE (In years last birthday) 11 yrs.	IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME Santford B. Montgomery			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None				
17. INFORMANT The Medical Record			18. MOTHER'S MAIDEN NAME Wanda Hott				
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			20. SOCIAL SECURITY NO. None				
21. INFORMANT The Clinical Center, Bethesda 14, Maryland			22. MOTHER'S MAIDEN NAME Wanda Hott				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram Negative Sepsis 2043 DUE TO (b) Acute Myelogenous Leukemia DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 2 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatic failure, 10 days; Renal failure, 3 days 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (this hospital) attended the deceased from December 10, 1965 to February 12, 1966 , that (we) last saw the deceased alive on February 12, 1966 , and that death occurred at 3:42M , from the causes and on the date stated above.							
22a. SIGNATURE Robert C. Gallo			22b. DATE SIGNED 12 February 1966				
22c. PHYSICIAN'S NAME (Type) Robert C. Gallo, M.D.			22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 15, 1966		23c. NAME OF CEMETERY OR CREMATORY Hott's Chapel			
23d. LOCATION (City, town or county) (State) Kirby West Virginia		24. FUNERAL DIRECTOR Tyson Wheeler 1331 Rockville Pike Rockville, Maryland					
25a. REC'D BY REGISTRAR FEB 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02560

CERTIFICATE OF DEATH

02525

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Damascus c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9510 Pleasant Plains Rd.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Damascus d. STREET ADDRESS 9510 Pleasant Plains Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Pearl Middle Estelle Last Moore		4. DATE OF DEATH Month Feb. Day 4 Year 1966		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 26, 1889		9. AGE (In years last birthday) 76 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Damascus, Md.		12. CITIZEN OF WHAT COUNTRY? USA													
13. FATHER'S NAME Levi W. Pearce						14. MOTHER'S MAIDEN NAME Marian Jones															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. --		17. INFORMANT Address Mrs Herman W. Mullinix, Damascus, Md.															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, Sigmoid Colon, 1533 DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 years Surgery 10/20/64											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No Injury																	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from October 1964 , to February 4 1966 , that (I) (✓) last saw the deceased alive on February 4, 1966 , and that death occurred at 1 P.M. from the causes and on the date stated above.																					
22a. SIGNATURE 						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/5/66													
22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M. D.						22d. ADDRESS 9701 Church Street Damascus, Maryland.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Feb. 7, 1966		23c. NAME OF CEMETERY OR CREMATORY Damascus Meth.				23d. LOCATION (City, town or county) (State) Damascus, Md.											
24 FUNERAL DIRECTOR'S SIGNATURE 						ADDRESS Damascus, Md.		25a. REC'D BY REGISTRAR DATE FEB 9 1966		25b. REGISTRAR'S SIGNATURE 											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02582

02582

CERTIFICATE OF MARRIAGE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02526

02561

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lakoma Park				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanatorium				d. STREET ADDRESS 9815 East Light Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Bernard Morse				4. DATE OF DEATH Feb. 17 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1885	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 17 Days 17 Hours 19 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Worker				10b. KIND OF BUSINESS OR INDUSTRY Shoe		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 013-09-8977		17. INFORMANT Arthur I. Morse, Son; same as 2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
INTERVAL BETWEEN ONSET AND DEATH 6 hrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Feb 17 , 19 66 , to Feb 17 , 19 66 , that I last saw the deceased alive on Feb 17 , 19 66 , and that death occurred at 3:20 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Sydney Leventhal M.D.				ADDRESS (Street, city or town, state) 9710 Colverville Rd., Silver Spring, Md.			
DATE SIGNED 2/17/66							
PHYSICIAN'S NAME (Type) Sydney Leventhal, M.D.				ADDRESS Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-1966		22c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery		22d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Haldberg Funeral Home				ADDRESS 4217-9th St N.W.		24a. REC'D BY REGISTRAR FEB 21 1966	
24b. REGISTRAR'S SIGNATURE Charles Judge							

2/17 Cleared with Dr. Beldan Keap - Medical Examiner's Office - Md.

02550

CERTIFICATE OF DEATH

10/1/50

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH 10/1/50		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Memphis, Tennessee	
7. CAUSE OF DEATH Suicide		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Alton, Illinois	
10. OCCUPATION Attorney		11. MARITAL STATUS Single		12. EDUCATION High School	
13. RELIGION Methodist		14. RACE White		15. COLOR White	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS John Edgar Hoover		18. SIGNATURE OF PHYSICIAN John Edgar Hoover	
19. SIGNATURE OF CLERK John Edgar Hoover		20. SIGNATURE OF JUDGE John Edgar Hoover		21. SIGNATURE OF DISTRICT ATTORNEY John Edgar Hoover	
22. SIGNATURE OF COUNTY CLERK John Edgar Hoover		23. SIGNATURE OF STATE CLERK John Edgar Hoover		24. SIGNATURE OF NATIONAL CLERK John Edgar Hoover	

1. NAME OF DECEASED
JAMES EARL RAY

2. SEX
Male

3. AGE
35

4. DATE OF DEATH
10/1/50

5. TIME OF DEATH
10:00 AM

6. PLACE OF DEATH
Memphis, Tennessee

7. CAUSE OF DEATH
Suicide

8. MANNER OF DEATH
Homicide

9. PLACE OF BIRTH
Alton, Illinois

10. OCCUPATION
Attorney

11. MARITAL STATUS
Single

12. EDUCATION
High School

13. RELIGION
Methodist

14. RACE
White

15. COLOR
White

16. SIGNATURE OF DECEASED
James Earl Ray

17. SIGNATURE OF WITNESS
John Edgar Hoover

18. SIGNATURE OF PHYSICIAN
John Edgar Hoover

19. SIGNATURE OF CLERK
John Edgar Hoover

20. SIGNATURE OF JUDGE
John Edgar Hoover

21. SIGNATURE OF DISTRICT ATTORNEY
John Edgar Hoover

22. SIGNATURE OF COUNTY CLERK
John Edgar Hoover

23. SIGNATURE OF STATE CLERK
John Edgar Hoover

24. SIGNATURE OF NATIONAL CLERK
John Edgar Hoover

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02562

02527

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jeanne L Mossrush</u>		4. DATE OF DEATH <u>Feb 22 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/1/1925</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleswoman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Colony Shop</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Shippen Rock, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Clara Dickson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>159-20-0711</u>	
17. INFORMANT <u>Wm J. Mossrush - Item #2</u>		Address <u>7720 Wisconsin Ave., Bethesda, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>201X</u> IMMEDIATE CAUSE (a) <u>Hodgkins Disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 18</u> , 19 <u>66</u> , to <u>Feb 22</u> , 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Feb 21</u> , 19 <u>66</u> , and that death occurred at <u>7:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>James W. Egan</u>		22b. DATE SIGNED <u>2-22-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>James W. Egan</u>		22d. ADDRESS <u>7720 Wisconsin Ave., Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/25/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1966</u>	
ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12321

UNITED STATES OF AMERICA

OFFICE

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RECEIVED JAN 10 1964

21
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02553

CERTIFICATE OF DEATH

02528

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY West	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Springfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 8121 Greeley Blvd.	
3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last MUROS		4. DATE OF DEATH Month Feb. Day 9 Year 1966	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1931
9. AGE (In years last birthday) yrs. 34		IF UNDER 1 YEAR Months 34 Days 3 Hours 3 Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Alexandria, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Warren M. Gettle		14. MOTHER'S MAIDEN NAME Hilda V. Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Springfield, Va. Ralph L. Muros, 8121 Greeley Blvd., West/		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanoma, malignant 1909 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from Jan. 4 , 19 66 , to Feb. 9 , 19 66 that (I) (we) last saw the deceased alive on Feb. 9 , 19 66 , and that death occurred at 12:01 P.M. from causes and on the date stated above.	
22a. SIGNATURE J. C. Johnson		22b. DATE SIGNED Feb. 9, 1966	
22c. PHYSICIAN'S NAME (Type) J. C. Johnson, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-11-66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR Everly & Wheatley, 1500 Braddock Rd. Alexandria, Va.		25a. REC'D BY REGISTRAR FEB 11 1966	
25b. REGISTRAR'S SIGNATURE John Charles Judge		25c. REGISTRAR'S SIGNATURE	

6250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02554

CERTIFICATE OF DEATH

02529

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 13020 Turkey Branch Parkway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth (N) Murray		4. DATE OF DEATH Month February Day 10 Year 1966	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1880
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 8 Days 8 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None Own home	
11. BIRTHPLACE (County & State, or foreign country) Pomonkey Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Crooke		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Edwin Murray		6829 Trexler Court Lanham, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hematoma DUE TO (b) Arterial hypertension DUE TO (c) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 20 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8 February, 1966 , to 10 February 1966 , that (I) (we) last saw the deceased alive on 10 February 1966 , and that death occurred at 6 P M, from causes and on the date stated above.			
22a. SIGNATURE W. L. Brannon Jr.		22b. DATE SIGNED 11 February 1966	
22c. PHYSICIAN'S NAME (Type) W. L. Brannon Jr. LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-14-66	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Bladensburg Maryland
24. FUNERAL DIRECTOR W. E. Pumphrey		25a. REC'D BY REGISTRAR FEB 16 1966	
Silver Spring, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02565

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02531

1. PLACE OF DEATH a. COUNTY Montgomery county b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4500 Conn Ave NW. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ELIZABETH		First ELIZABETH		Middle NEWBURN		Last NEWBURN		4. DATE OF DEATH Month FEBRUARY Day 15 Year 1966	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-5-1894		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (County & State, or foreign country) Lincoln, New York			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME KERN				14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. E.G. Weiss, Same as 2d Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA (LEFT BREAST) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 13.40.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SENILITY								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-2 , 19 62 , to FEB. 15 , 19 66 , that (I) (we) last saw the deceased alive on FEB 15 1966 , and that death occurred at 2:10 M. , from the causes and on the date stated above.									
22a. SIGNATURE Henry L. Louden						22b. DATE SIGNED 2/15/66		22c. PHYSICIAN'S NAME (Type) Lee Crematory	
22d. ADDRESS 5206 NORWAY DR. CHEVY CHASE, MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Feb 16, 66		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory			23d. LOCATION (City, town or county) (State) Washington, DC		
24. FUNERAL DIRECTOR Lee Funeral Home, 300 4th St, NE Wash DC				25a. REC'D BY REGISTRAR FEB 18 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

05280

05280

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02566

CERTIFICATE OF DEATH

02531

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN 1b <i>30 days</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg, Maryland</i> d. STREET ADDRESS <i>209 Lee St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Thomas Clint Nichols</i>		4. DATE OF DEATH Month Day Year <i>2-6 1966</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-27-31</i>
9. AGE (In years last birthday) <i>34</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shoeleather Operator City-Lux, Inc.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William H. Nichols</i>		14. MOTHER'S MAIDEN NAME <i>Marie Bennett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO. <i>Yes</i>	
17. INFORMANT <i>Marie Nichols - Mother</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular disease</i> <i>5810</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic pancreatitis</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/7/66</i> , 1966, to <i>2/5</i> , 1966 that (I) (we) last saw the deceased alive on <i>2/5</i> , 1966, and that death occurred at <i>3:15 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Fredrick Y. Down</i>		22b. DATE SIGNED <i>2/6/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>FREDERICK Y. DOWN</i>		22d. ADDRESS <i>800 Pershing Dr., Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-9-66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Darnestown Presbyterian Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Darnestown, Md.</i>	
24. FUNERAL DIRECTOR <i>C. Glen Carter</i>		25a. REC'D BY REGISTRAR <i>Warner E. Pumphrey, Inc.</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>FEB 10 1966</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

105234

RECEIVED 10 JANUARY

3333

Handwritten signature

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02567

02532

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. STREET ADDRESS 1028 University Blvd. East #913		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emil Oettinger		4. DATE OF DEATH Feb. 25 1966		5. AGE (In years last birthday) 64 yrs.	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/28/1901	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Broker		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Bavaria, Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Sally Oettinger		14. MOTHER'S MAIDEN NAME Dolce Ullmann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 1028 University Blvd.		17. INFORMANT Mrs. Kaethe Oettinger Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Coronary Artery Heart Disease DUE TO (c) Coronary Artery Heart Disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Belden R. Reap		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Feb. 26, 1966	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB 27, 1966		22c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY	
22d. LOCATION (City, town, or county) HYATTSVILLE		(State) MD.		24b. REC'D BY REGISTRAR MAR 2 1966	
23. FUNERAL DIRECTOR B. DANZANSKY + SONS		ADDRESS 3505 14th ST. N.W. WASH. D.C.		24c. REGISTRAR'S SIGNATURE Charles Judge	

STATE OF NEW YORK
IN SENATE
JANUARY 10, 1911
REPORT
OF THE
COMMISSIONER OF THE
DEPARTMENT OF
CORRECTIONS
AND
JAIL REFORMS
FOR THE
YEAR
1910
ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS.
1911.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
02558					02533				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN <u>2 yrs - 7 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10418 Royal Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>Ohlbaum</u> Last <u>Ohlbaum</u>					4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-18-72</u>		9. AGE (In years last birthday) <u>93</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garage Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Solomon Ohlbaum</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <u>Stanley H. Ohlbaum - 10418 Royal Rd. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Cerebral Arteriosclerosis, Probable Ca Prostate</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jul</u> , 19 <u>63</u> , to <u>2/1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/27</u> , 19 <u>66</u> , and that death occurred at <u>9P</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Ira N. Tublin</u>				22b. DATE SIGNED				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>IRA N. Tublin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <u>25 E. Wayne Ave. S.S. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>mt. Hebron Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>New York, N.Y.</u>			
24. FUNERAL DIRECTOR <u>B. Danzansky & Sons</u>				ADDRESS <u>3501-14 ST. N.W. Wash D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1872

1872



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Item #9 Film #6373 2/11/66 p

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia		b. COUNTY 83-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 214 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital Bethesda				d. STREET ADDRESS 7421 Farnum Street			
3. NAME OF DECEASED (Type or print) Leonard		First Joseph		Middle Opeil		4. DATE OF DEATH February 4 19 66	
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 5 1917	
9. AGE (In years last birthday) 49/48 yrs.		10. AGE (In years last birthday) 49/48 yrs.		11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Opeil				14. MOTHER'S MAIDEN NAME Mary Benner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 281-14-1428		17. INFORMANT Susan E. Opeil		18. ADDRESS 7421 Farnum St. Springfield, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma 2002 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) OUE TD (c)						INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from July 1965, to Feb 1966, that (we) last saw the deceased alive on Feb 1966, and that death occurred at 4:33 PM, from the causes and on the date stated above.							
22a. SIGNATURE R.B. Moquin LCDR MC USN						22b. DATE SIGNED 5 February 1966	
22c. PHYSICIAN'S NAME (Type) R.B. Moquin LCDR MC USN						22d. ADDRESS U.S. Naval Hospital Bethesda Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2/9/66		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL		23d. LOCATION (City, town or county) (State) ARLINGTON VA.	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO		24a. ADDRESS WASHINGTON DC		25a. REC'D BY REGISTRAR FEB 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

1878

1878

Washington

St. Louis

John Brown

John Brown

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02570

02535

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>13 hrs 40 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park</u> d. STREET ADDRESS <u>6509 C. St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lillian Marie Ortman</u> First Middle Last			4. DATE OF DEATH <u>2-23-1966</u> Month Day Year				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-06</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia, U.S.A.</u>			
13. FATHER'S NAME <u>William Fitzpatrick</u>			14. MOTHER'S MAIDEN NAME <u>Mary Horner</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of lung</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <u>405</u> <u>405</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1965</u> to <u>Feb. 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb. 22, 1966</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Albert H. Grollman</u> 22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN</u> <u>1106 Spring St.</u>				22b. DATE SIGNED 22d. ADDRESS <u>1106 Spring St. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2-26-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>			
24. FUNERAL DIRECTOR <u>See Funeral Home</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>		25a. REC'D BY REGISTRAR <u>FEB 28 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

95535

CERTIFICATE OF DEATH

270

(3)

Longwood
James H. ...
Born ...
Died ...
Cause of death ...
Buried ...
Witnessed by ...
Minister of the Gospel ...
Physician ...
County Clerk ...

Attest my hand and the seal of the County of ...
this ... day of ... A.D. 19...
County Clerk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

(M)

02571

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02536

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>37 1/2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry, Chase</u> 15-1 d. STREET ADDRESS <u>3616 Sprung Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>WILLIAM FREDERICK PAHREN</u>		4. DATE OF DEATH <u>2</u> Month <u>24</u> Day <u>19</u> Year <u>66</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-19-81</u>		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical Head Section</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office U. S. Govt.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>GERMANY</u>				12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>			
13. FATHER'S NAME <u>ALBERT</u>				14. MOTHER'S MAIDEN NAME <u>NONE RECORDED</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Washington Sanitarium and Hospital, Takoma Park</u> Address <u>HOSPITAL RECORDS (CHART)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Post. pneumonia - urinary tract infection</u>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>65</u> , to <u>2-24</u> , 19 <u>66</u> , that (I) (was) last saw the deceased alive on <u>2-24</u> 19 <u>66</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.															
22a. SIGNATURE <u>Morrill C. Quinnan</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>Jakoma Pk.</u>							
22c. PHYSICIAN'S NAME (Type) <u>Morrill C. Quinnan</u>				22d. ADDRESS <u>831 University Blvd., Est.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>Feb 25, 1966</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>				23d. LOCATION (City, town or county) <u>Washington, D. C.</u> (State) <u>Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>				25a. REG'D BY REGISTRAR <u>FEB 28 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02572		Item 9 Film 6274 2/20/66 mh						02537			
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN lb 3 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON SANITARIUM & Hosp.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 9116 Georgia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MONA MARGARET PALMER		First		Middle		Last		4. DATE OF DEATH FEBRUARY 15 1966		Month Day Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 June 1904		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR IF FUNER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICAL NURSE				10b. KIND OF BUSINESS OR INDUSTRY Nursing				11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABRAHAM FLINT						14. MOTHER'S MAIDEN NAME Emily Roby					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) NO				16. SOCIAL SECURITY NO. 212-24-4002		17. INFORMANT Hospital chart		Address WILLIAM SMITH 7112 GA. AVE SILVER SPRING MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) DIABETES MELLITUS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-25- , 19 66 , to 2/15 , 19 66 , that (I) (we) last saw the deceased alive on 2/15 , 19 66 , and that death occurred at 10:40 AM, from the causes and on the date stated above.											
22a. SIGNATURE Richard H. Pollen						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/16/66			
22c. PHYSICIAN'S NAME (Type) RICHARD H. POLLEN MD						22d. ADDRESS 10511 SUMMIT AVE, KENSINGTON MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 19 Feb 1966		23c. NAME OF CEMETERY OR CREMATORY Maplelawn, XXXX				23d. LOCATION (City, town or county) (State) Weston, West Virginia			
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc.						ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR FEB 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

12

1. The first part of the document discusses the importance of maintaining accurate records of all transactions, both incoming and outgoing, to ensure transparency and accountability. It emphasizes the need for regular audits and the use of reliable accounting software to track every dollar spent or received.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02573 CERTIFICATE OF DEATH 02538											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>New York NY</u> b. COUNTY <u>Albany</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SHARPLEIGH</u> <u>69-3</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL - SILVER SPRING</u>						d. STREET ADDRESS <u>209 N. Maraine</u>					
3. NAME OF DECEASED (Type or print) <u>HELEN G PALMETER</u>			First Middle Last			4. DATE OF DEATH <u>FEB 14 1966</u>			Month Day Year		
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-16-1880</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John H. Allyn</u>						14. MOTHER'S MAIDEN NAME <u>Rhoda Woodward</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>069-03-9708</u>		17. INFORMANT <u>Mrs. Ruth Stokoe</u> <u>9306 Montwood St. Silver Spring, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEBROVASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>13 HRS</u> <u>20 YRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> , 19 <u>66</u> , to <u>2/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/13</u> , 19 <u>66</u> , and that death occurred at <u>2:20 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Henry W Stout</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>2/14/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>HENRY W STOUT M.D.</u>						22d. ADDRESS <u>10011 Georgia, Silver Spring, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Feb 17 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Souls Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Albany New York</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey</u>						25a. REC'D BY REGISTRAR <u>Feb 16 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

April 6

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BETHESDA-SILVERSPRING N.H.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVERSPRING 15-1</u> d. STREET ADDRESS <u>8508 16th ST. APT. #404</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>ABRAHAM N. PARSON</u> First Middle Last			4. DATE OF DEATH <u>FEB. 11, 1966</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>APR. 21, 1888</u> Yrs. Months Days			9. AGE (in years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLEANING BUSINESS</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u> 11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Nota E. Parson</u> 14. MOTHER'S MAIDEN NAME <u>unk.</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>(Son) NORMAN PARSON</u> Address <u>1000 GREENLEAF RD. DISTRICT HEIGHTS MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinome of Stomach c metastases</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>over 6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June, 1947</u> , to <u>Feb 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 9</u> 19 <u>66</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Louis H. Shuman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb 11, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Louis H. Shuman, M.D.</u>				22d. ADDRESS <u>1635 Mass Ave N.W. Wash. D.C. 20036</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/13/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hyattsville, Md.</u>			
24. FUNERAL DIRECTOR <u>B. DANZANSKY & SONS 3501 14th St. NW</u>				25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

18750

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FOR STATE
HEALTH DEPT.

02575

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02540

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Hospital</i>		d. STREET ADDRESS <i>500 Tulip Ave.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Sarah Miller Parsons</i>		4. DATE OF DEATH Month Day Year <i>2 22 19 66</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>1-27-85</i>
9. AGE (In years last birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Tanna</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Miller</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Seever Thorne</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Ruth Brandt</i>		Address <i>500 Tulip Ave. Takoma Park Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary insufficiency;</i> DUE TO (b) <i>Arteriosclerotic heart disease.</i> DUE TO (c) <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <i>Feb. 22, 1966</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>V</i>	23b. DATE THEREOF <i>Feb 25-1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fernwood Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Cumbarland Co. New Jersey</i>
24. FUNERAL DIRECTOR <i>Arthur Ketter</i>		25a. REC'D BY REGISTRAR DATE <i>B 25 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(1472)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02576

CERTIFICATE OF DEATH

02541

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D. C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, (rural)</u>		c. LENGTH OF STAY in 1b <u>8 hours</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <u>15 Sextant Green, S. W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Pearson</u>		4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Feb. 1966</u>
9. AGE (In years last birthday) yrs. <u>47-3</u>		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ronald K. Pearson</u>		14. MOTHER'S MAIDEN NAME <u>Ione Marie Baston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NA</u>	
17. INFORMANT <u>Ronald K. Pearson</u>		18. <u>15 Sextant Green</u> <u>S. W. Washington, D. C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>Feb. 19</u> , 19 <u>66</u> , to <u>Feb. 19</u> , 19 <u>66</u> that (X) (we) last saw the deceased alive on <u>Feb. 19</u> , 19 <u>66</u> , and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R. F. Swanger</u>		22b. DATE SIGNED <u>Feb. 21, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. F. Swanger LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-24-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington, Virginia</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Simmons Brothers Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
1661 Goodhope Road, S. E. Washington, D. C.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

6-203717

14730

STATE OF TEXAS

03336

COUNTY OF DALLAS		CITY OF DALLAS	
DECEASED		DATE OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
AGE		SEX	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
FAMILY HISTORY		SOCIAL HISTORY	
HISTORY OF PRESENT ILLNESS		PHYSICAL EXAMINATION	
LABORATORY EXAMINATIONS		PATHOLOGICAL FINDINGS	
TREATMENT		PROGNOSIS	
FOLLOW-UP		DISPOSITION	

1. I, the undersigned, being a duly qualified physician and surgeon, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased, as far as I am personally concerned.

2. I further certify that the deceased was at the time of death, in the full possession of his or her mind and faculties, and that the death was not caused by any illegal or immoral act of the deceased.

3. I further certify that the deceased was at the time of death, in the full possession of his or her mind and faculties, and that the death was not caused by any illegal or immoral act of the deceased.

4. I further certify that the deceased was at the time of death, in the full possession of his or her mind and faculties, and that the death was not caused by any illegal or immoral act of the deceased.

5. I further certify that the deceased was at the time of death, in the full possession of his or her mind and faculties, and that the death was not caused by any illegal or immoral act of the deceased.

6. I further certify that the deceased was at the time of death, in the full possession of his or her mind and faculties, and that the death was not caused by any illegal or immoral act of the deceased.

7. I further certify that the deceased was at the time of death, in the full possession of his or her mind and faculties, and that the death was not caused by any illegal or immoral act of the deceased.

8. I further certify that the deceased was at the time of death, in the full possession of his or her mind and faculties, and that the death was not caused by any illegal or immoral act of the deceased.

9. I further certify that the deceased was at the time of death, in the full possession of his or her mind and faculties, and that the death was not caused by any illegal or immoral act of the deceased.

10. I further certify that the deceased was at the time of death, in the full possession of his or her mind and faculties, and that the death was not caused by any illegal or immoral act of the deceased.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8711 Leonard Drive</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8711 Leonard Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Louisa Rita Pearson</u>						4. DATE OF DEATH Month <u>2</u> - Day <u>9</u> - Year <u>1966</u>					
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-5-1908</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George H. Pearson</u>						14. MOTHER'S MAIDEN NAME <u>Margaret B. Conway</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Silver Spring, MD</u> <u>Miss ADA Henry - 8711 Leonard Drive</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery heart disease</u> DUE TO (c) <u>PENDING</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap</u>						22. DATE SIGNED <u>Feb. 9, 1966</u>					
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u> </u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-14-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
ADDRESS <u>Ave. N.W. Wash. D.C.</u>						DATE <u>FEB 16 1966</u>					

FOR STATE
RECORD ONLY

0257

0254

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK

COUNTY OF ...

CITY OF ...

DECEASED ...

DATE OF DEATH ...

PLACE OF DEATH ...

CAUSE OF DEATH ...

MANNER OF DEATH ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>50 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center Of Health</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>3 Pooks Hill Road, Apt. 419</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Dorit</u> Middle <u>(No middle name)</u> Last <u>Perk</u>					4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 10, 1960</u>		9. AGE (In years last birthday) <u>6</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Israel</u>		12. CITIZEN OF WHAT COUNTRY? <u>Israel</u>	
13. FATHER'S NAME <u>Kalman Perk</u>					14. MOTHER'S MAIDEN NAME <u>Ruth Yahalom</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probable generalized Fungal Infection</u> DUE TO (c) <u>Acute Lymphocytic Leukemia</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>15 Days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 19, 1965</u> , to <u>February 7, 1966</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>February 7, 1966</u> , and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Theodore S. Zimmerman</u> 22c. PHYSICIAN'S NAME (Type) <u>Theodore S. Zimmerman, MD.</u>								22b. DATE SIGNED <u>7 February 1966</u>	
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		23b. DATE THEREOF <u>2/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Gdn. Falls Church, Virginia.</u>		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <u>B. DANZANSKY & SONS 35 01 14th St. N.W.</u>						25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02579

02544

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> c. LENGTH OF STAY IN 1b <u>5 1/2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> d. STREET ADDRESS <u>805 BRICE ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY ELIZABETH PERRY</u> (ELIZABETH M. PERRY)				4. DATE OF DEATH Last Month Day Year <u>FEB 3 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>MARCH 20 1887</u>			
9. AGE (In years last birthday) <u>78 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____			
11. BIRTHPLACE (County & State, or foreign country) <u>BROCKTON MASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>JOHN PERRY THORNELL</u>			
14. MOTHER'S MAIDEN NAME <u>MARY HAYES</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>013-09-0018</u>			
17. INFORMANT <u>MRS FRED MCCANN</u>		18. ADDRESS <u>805 BRICE ROAD</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY</u> <u>4201</u> DUE TO (b) <u>Arteriosclerotic Cardio Vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>with hypertension</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>10-29</u> <u>1963</u> , to <u>2-3</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>1-21</u> <u>1966</u> , and that death occurred at <u>11:15 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Sarah E. Glover</u>				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>SARAH E. GLOVER</u>				22d. ADDRESS <u>1612 CEDAR LAKE KENSINGTON MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/5/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks</u>			
23d. LOCATION (City, town or county) <u>Brockton, Mass.</u>		(State) _____		24 FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>			
24b. ADDRESS <u>1331 Rockville Pike</u>		24c. CITY <u>Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE _____					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02541

CERTIFICATE OF DEATH

1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

02580

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02545

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>7 mo 10 da</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington GARDENS</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>6820 Millwood Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ELMER</u> First <u>S</u> Middle <u>Petry</u> Last 4. DATE OF DEATH <u>Feb</u> Month <u>25</u> Day <u>19</u> Year <u>66</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov 19 1887</u> 9. AGE (In years last birthday) <u>78</u> yrs. 10. IF UNDER 1 YEAR Months <u>3</u> Days <u>6</u> 11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Michael Petry</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>275-10-8557</u> 17. INFORMANT <u>6820</u> Address <u>C.A. Petry - Millwood Road, Bethesda, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO <u>Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Bronchopneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bronchopneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>3-6 days</u> <u>Unknown</u> <u>Unknown</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>May 7 1965</u> to <u>Feb 25 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 25 1966</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>George Sharp</u> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>George Sharp</u> 22d. ADDRESS <u>Kensington, Md.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u> 23b. DATE THEREOF <u>2/28/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Dade Memorial Park</u> 23d. LOCATION (City, town or county) (State) <u>Opalocka, Florida</u>			
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> ADDRESS <u>Funeral Home-1331 Rockville Pike Rockville, Md.</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>MAR 3 1966</u>							

MEDICAL CERTIFICATION

05340

05340

2-0-0-0-0
1-0-0-0-0
1-0-0-0-0

Pyramis
Pyramis
Pyramis
Pyramis

1-0-0-0-0 1-0-0-0-0 1-0-0-0-0 1-0-0-0-0 1-0-0-0-0

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02589

02546

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY in lb <u>16 Months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carrol Hall Nursing Home</u>		d. STREET ADDRESS <u>3517 Rodman Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hugh</u> Middle <u>Edward</u> Last <u>Phillips</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/1881</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>26</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Melvin W. Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Ester Virginia Hickson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-50-1497</u>	
17. INFORMANT <u>Daughter</u>		Address <u>Mrs. F.M. Hoffheins</u> Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Bronchial -</u> <u>9047</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of Left Hip -</u> DUE TO (c) <u>Generalized Arterio Sclerosis -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>21 days</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell and fractured left hip</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2/11/1966</u> a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. (City or town) (County) (State) <u>Kensington Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		22. DATE SIGNED <u>2/21/66</u> Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-24-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1966</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

05246

05246

870-50-1007

JOHN E. BAKER

870-50-1007

JOHN E. BAKER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MONTGOMERY COUNTY, MARYLAND									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>D.C.</u> b. COUNTY <u>1</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN IL <u>15 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Congressional Manor Sanitarium</u>					d. STREET ADDRESS <u>6345 Western Ave. N.W.</u>				
3. NAME OF DECEASED (Type or print) <u>MARY BROGDEN PINNEY</u>					4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 17-1873</u>		9. AGE (In years last birthday) <u>92</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		
13. FATHER'S NAME <u>Arthur Brogden</u>					14. MOTHER'S MAIDEN NAME <u>Mary Mercer</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-64-5968</u>		17. INFORMANT Address <u>Frank Pinney, 6345 Western Ave. N.W. D.C. Son</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIO-SCLEROTIC C.V. Disease</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 24</u> <u>1966</u> to <u>Feb 24</u> <u>1966</u> , that (I) (was) last saw the deceased alive on <u>Feb 24</u> <u>1966</u> , and that death occurred at <u>11:05</u> M., from the causes and on the date stated above.									
22a. SIGNATURE <u>DeWitt E. DeLawter</u>					22b. DATE SIGNED <u>2/25/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>DEWITT E. DELAWTER</u>					22d. ADDRESS <u>8025 ARBORNERS Bethesda Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/28/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) <u>Arlington, Virginia</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>TYSON WHEELER FUNERAL HOME</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>				
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					25c. DATE <u>MAR 1 1966</u>				

05247

STATEMENT OF DEATH

1938

10

Name of deceased		Date of death	
Sex		Age	
Place of birth		Date of birth	
Cause of death		Place of death	
Occupation		Marital status	
Signature of declarant		Signature of witness	
Date of statement		Place of statement	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02583

CERTIFICATE OF DEATH

02548

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland D.C.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington Washington D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3000 Ellicott St. NW</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Elizabeth Pirie</u>		4. DATE OF DEATH Month Day Year <u>Feb 3 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/14/1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Monumental Co.</u>	9. AGE (In years last birthday) <u>83</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia, Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Garnet N. Schwemmer</u>		14. MOTHER'S MAIDEN NAME <u>Anna STURGES MANUEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>578-34-1053</u>	17. INFORMANT <u>Raymond M. Pirie</u> Address <u>3000 Ellicott St. NW</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion and edema</u> 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic pyelonephritis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 18</u> , 19 <u>66</u> , to <u>Feb 3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 2</u> , 19 <u>66</u> , and that death occurred at <u>12:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Feb 3, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>921-20th St NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/7/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>JOSEPH GAWLER'S SONS</u>		25a. REC'D BY REGISTRAR <u>WILSON AVE. WASHINGTON, D.C.</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0524X

0524X

THE STATE OF TEXAS,
COUNTY OF DALLAS.

NOTARY PUBLIC FOR THE STATE OF TEXAS,
My Commission Expires: 08/15/2011
I, _____, do hereby certify that _____
is the true and correct copy of the _____
as the same appears of record in my office.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
02584					02549				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>1218 Dale Drive</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1 d. STREET ADDRESS <u>1218 Dale Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>C.</u> Last <u>Plaskett</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>19</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 1, 1881</u>		9. AGE (In years last birthday) <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Charles Coleman</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Haislip</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>Rosemary Louft</u> Address <u>Same as #2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis - myocardial infarction</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Gen. arteriosclerotic cardiac disease 2 yrs.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 m.</u>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19____, to <u>19 Feb</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>19 Feb</u> , 19 <u>66</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Ernest C. Harmon</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>De. Ernest Harmon</u> 22d. ADDRESS <u>9301 Colesville Rd, Silver Sp., Md</u> 22b. DATE SIGNED <u>19 Feb 66</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2/19/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Washington DC</u>			
24. FUNERAL DIRECTOR <u>J. Wm. Lees Sons</u> ADDRESS <u>300 4th St., NE, Wash. D.C.</u>					25a. REC'D BY REGISTRAR <u>FEB 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

95249

95249

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>10 days + 8 hrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> <u>15-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM AND HOSPITAL</u>						d. STREET ADDRESS <u>516 NELSON STREET</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>HAROLD</u> Last <u>PORSCH</u>						4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-6-26</u>		9. AGE (in years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief SITE PLANNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERNMENT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Erie PENNA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>WILLIAM E. PORSCH</u>						14. MOTHER'S MAIDEN NAME <u>ELEANORE BUGNO</u>					
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>210-18-6193</u>		17. INFORMANT <u>Mary Lou Porsch</u>		Address <u>516 Nelson Street Rockville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Violent Aspiration, Cardiac arrest</u> <u>330X</u> OUE TO (b) <u>Producing myocardial infarction</u> 3 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (c) <u>Ruptured intracranial aneurysm</u> 2 weeks PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Craniotomy and clipping of aneurysm 2/1/66</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/26</u> 19 <u>66</u> , to <u>2/5</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/4</u> 19 <u>66</u> and that death occurred at <u>4:00 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>John T. Lord</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/5/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>John T. Lord</u>						22d. ADDRESS <u>1015 Spring St. Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-9-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Chambersburg, Penna.</u>			
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>						ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

05250

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

02586

02551

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6404-Wilson La.</u>	
3. NAME OF DECEASED (Type or print) <u>Rachel</u> First Middle Last <u>Posner</u>		4. DATE OF DEATH <u>Feb.</u> Month <u>24</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/15/77</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		9b. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Shapiro</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Katz?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Sylvia Goodman</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchio. Pneumonia.</u> DUE TO (b) <u>Cardio Vascular Disease -</u> DUE TO (c) <u>Cere. Generalized. Arterio Sclerosis -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u> <u>years.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/24/66</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/27/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LUBAVITCH CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BUFFALO N.Y.</u>	
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u>		25a. REGD BY REGISTRAR <u>FEB 28 1966</u>	
ADDRESS <u>4217-92nd N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1055

1055



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02587 CERTIFICATE OF DEATH 02552

1. PLACE OF DEATH a. COUNTY <u>Mont</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sevier Spring</u> c. LENGTH OF STAY IN 1b <u>1 wk</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sevier Spring</u> d. STREET ADDRESS <u>8931 Brookville Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary H. Potts</u> First Middle Last 4. DATE OF DEATH <u>2/15/66</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/2/11</u> 9. AGE (In years last birthday) <u>54</u> yrs. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>PHILLIP EAGLEN</u> 14. MOTHER'S MAIDEN NAME <u>CAROLINE BELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <input type="checkbox"/> 17. INFORMANT <u>CARRIE BARNES</u> Address <u>8921 Road Brookville</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>65</u> , to <u>Feb 5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 4</u> , 19 <u>66</u> , and that death occurred at <u>1:15</u> M., from the causes and on the date stated above. 22a. SIGNATURE <u>Lemeshay</u> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.</u> 22d. ADDRESS	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2-19-1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>CARVER</u> 23d. LOCATION (City, town or county) (State) <u>BELTSVILLE, Maryland</u>		24. FUNERAL DIRECTOR <u>W.E. Jarvis</u> Address <u>1432 York St NW</u> 25a. REC'D BY REGISTRAR <u>FEB 9 1966</u> 25b. REGISTRAR'S SIGNATURE <u>John R. Judge</u>	

15550

HYPERBOLIC

15550

[Faint, illegible handwriting covering the majority of the page, possibly bleed-through from the reverse side.]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>02588</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>02553</p> </div> </div>															
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RESMOR</u> c. LENGTH OF STAY IN 1b <u>4 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Resmor Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POTOMAC</u> d. STREET ADDRESS <u>11209 Gainsborough Road Potomac MARYLAND</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>MATTIE</u> <u>Y</u> <u>POWELL</u>				4. DATE OF DEATH Month Day Year <u>February</u> <u>5</u> <u>1966</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>June 24, 1887</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>				13. FATHER'S NAME <u>JONATHAN Jenkins</u> 14. MOTHER'S MAIDEN NAME <u>PATTY LANCASTER</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>145</u> 17. INFORMANT <u>Hospital Record</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO (b) <u>Senile Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>4500</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonism</u>												INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)															
21. I certify that <u>Dr</u> (this hospital) attended the deceased from <u>Sept 20, 1966</u> to <u>Feb 5, 1966</u> , that <u>he</u> (we) last saw the deceased alive on <u>Feb 5, 1966</u> , and that death occurred at <u>145</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>P.P. Andrews</u> 22c. PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS</u>				22b. DATE SIGNED <u>2-5-66</u> 22d. ADDRESS <u>WASHINGTON, D.C.</u>				22e. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> 23b. DATE THEREOF <u>2/8/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Maplewood Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Wilson, N.C.</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chuan Tunk Hono</u> ADDRESS <u>510 1/2 King Ave NW Washington</u>											

MEDICAL CERTIFICATION

822

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville Md</u> c. LENGTH OF STAY IN b <u>10 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville, Md 15-1</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Snagge Proctor</u> First Middle Last 4. DATE OF DEATH <u>Feb 9 1966</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct 10, 1874</u> 9. AGE (In years last birthday) <u>91</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Fredrick Co. Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Spencer</u> 14. MOTHER'S MAIDEN NAME <u>Martha Stevenson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO <u>Mitral Regurgitation & Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>also Obstructive Jaundice from Hepatitis</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> <u>6 ys</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct-15-49</u> , 19 <u>49</u> , to <u>Feb 4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 24</u> , 19 <u>65</u> , and that death occurred at <u>7.20</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J.M. Baxter</u> 22c. PHYSICIAN'S NAME (Type) <u>J M BAXTER MD</u>		22b. DATE SIGNED <u>Feb-10-66</u> 22d. ADDRESS <u>Fredrick Md. 21701</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF <u>2/13/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Bells Chapel.</u> 23d. LOCATION (City, town or county) (State) <u>Dickerson, Md.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Robert L. Snowden Rockville, Md.</u> 25a. REC'D BY REGISTRAR DATE <u>FEB 14 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

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J. M. GAYLOR MD

FEB 11 1963